Authorization for Authorized Representative to Access Patient Portal

The Mahaska Health Patient Portal, myMHP, is an electronic tool that offers patients personalized access to portions of their medical records. It enables them to securely use the Internet to help manage and receive information about their healthcare.

Patients may grant proxy access to their myMHP account. The person granted proxy will be able to view and manage information in the patient's myMHP account, including any information provided through the patient's medical health record and information added by the patient. Examples could include information relating to substance abuse (including alcohol/drug abuse), mental health and HIV/AIDS related information (including test results), or pregnancy.

Patient Name: ____ **Patient DOB:** __________________

Patient Address: ____ **Patient Phone #:** ________________

Patient City: ____________________________________ **Patient State:** __________ **Patient Zip:** ______

This proxy is given at my request.

I hereby designate the following individual as an authorized proxy for the purpose of accessing my myMHP account:

AUTHORIZED PROXY

Proxy Name: ____________________________ Relationship to Patient: __________ Proxy Phone #: __________

Proxy Address: ______________________________________ Email: ________________________________

I hereby authorize Mahaska Health to grant access to my myMHP account to the authorized proxy identified above.

I understand and acknowledge that:

1. My refusal to sign this authorization will not affect my ability to obtain treatment at Mahaska Health Partnership.
2. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by state or federal law.
3. This proxy is effective until my death, unless earlier revoked by me. I understand that I may revoke this proxy at any time by giving written notice to Mahaska Health Partnership. My revocation will not be effective to the extent action has already been taken in reliance on my authorization.
4. I have read (or had read to me) and have received a copy of this document.

A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

____ _________________________

Signature of Patient Date

____ _________________________

Signature of Witness Date