UNIVERSITY of VIRGINIA HEALTH SYSTEM | Culpeper Hospital

Place Label Here

If no Label, write pt name and MR#

ADULT PROXY ACCESS BY ANOTHER ADULT PROXY

Please send the completed form to:

U.S. Mail: UVA Culpeper Hospital, Culpeper, VA 22701 ATT Medical Records

Email: MyHealthConnection@culpeperhospital.com **Fax: 540.829.4326**

Patient's Name _____ Medical Record Number _____

Date Of Birth _____ Gender ☐ M ☐ F Address _____

Patient's email address o none _____

Adult seeking proxy access *(In person or by phone)*

Name _____ Phone _____

Address _____

Date Of Birth _____ Email: _____

 Patient – MRN_____ (Must have your own MyHealthConnection account)

 If you are not the Patient, check the box that describes your relationship to the patient: o Spouse o Son/Daughter o Other- Please specify:

Patients:

I have read and understand the information about proxy for MyHealthConnection and terms and conditions for using MyHealthConnection. I authorize the above named person to access my MyHealthConnection account. This authorization begins when MyHealthConnection Proxy is initiated, and will continue until I cancel it. I understand that I may cancel this authorization at any time by contacting Medical Records at **540.829.8848** and asking to have my MyHealthConnection Proxy deactivated. This action will not affect any information released prior to notification of cancellation. I understand that the information disclosed may be subject to re-disclosure by my proxy, and would then no longer be protected by federal privacy laws. I understand that UVA Culpeper Hospital may not condition its providing of health care on whether I sign this authorization. If I have any questions or concerns about the confidentiality of my health information I can call Medical Records at **540.829.8848**.

Name

_____

Signature _____ Date_____ Time_____

For Adult Proxy:

I have read and understand the information about proxy for MyHealthConnection and terms and conditions for using MyHealthConnection. I request access to the above named patient's MyHealthConnection Account.

Name_____

Signature _____ Date_____ Time_____

 Proxy identification validated by Medical Records Staff *Other–Role:*_____

Completed by: StaffName/Signature/Role_____Date_____Time_____

Activation code generated and provided to proxy by: Medical Records Staff *Other Role:*

*Staff Name*_____ *Date*_____ *Time*_____

Proxy deactivated per request of patient by*: Medical Records Staff Other-Role:*_____

*Staff Name*_____ *Date*_____ *Time*_____