BOONE COUNTY HOSPITAL

Proxy Access to Your Health Portal - Adult (18 years and older)

Please complete this form and return to a member of our registration staff or mail: Boone County Hospital Health Information Management 1015 Union St. Boone, IA 50036 or fax (515) 433-8988 or email: portalhelp@bchmail.org
ALL SECTIONS REQUIRED - PLEASE PRINT CLEARLY

Patient Information:

Name: _____ _____ _____ Sex: _____
(Last Name) (First Name) (Middle Initial)

SSN: _____ / _____ / _____ Date of Birth: _____ / _____ / _____

Address: _____ _____ _____ _____
Street: City: State: Zip:

Phone: (___)_____ (___) _____ Email: _____ @ _____
Home Cell

Proxy Information:

Name: _____ _____ _____ Sex: _____
(Last Name) (First Name) (Middle Initial)

SSN: _____ / _____ / _____ Date of Birth: _____ / _____ / _____ Relationship to Patient: : _____

Address: _____ _____ _____ _____
Street: City: State: Zip:

Phone: (___)_____ (___) _____ Email: _____ @ _____
Home Cell

Does the Proxy Currently have a BCH Health Portal: ___
(A "Yes" indicates the Proxy requester already has a Health Portal Access.)

Type of Request (Choose One):

____ Patient requesting another individual have access to their Health Portal.
____ Proxy access due to patient's impaired decision-making capacity. Signed approval may be requested from the patient's provider or designated administrator. You will need to provide HPOA (Healthcare Power of Attorney) or other legal documentation as proof of your right to access this information.

Proxy Health Portal Terms and Conditions:

- I authorize release of any medical information including any protected health information.
- I understand my information is obtained from my electronic medical record and may include Substance Abuse, Mental Health HIV/AIDS/STDS/Other Infectious Disease and Genetic Information.
- I authorize release of information only through the Health Portal to my proxy. This form does not authorize release of information in any other form.
- I understand this is intended as a secure online source of confidential medical information. If the user ID and password are shared with another person, that person may be able to view this information. I understand once information has been disclosed, it potentially may be re-disclosed by the proxy and may not be covered by federal privacy protections. I agree it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if my password is compromised.
- I understand the Health Portal contains select, limited medical information from a patient's medical record and does not reflect complete records. I understand I may make a request for a copy of the record. I understand access to the Health Portal may be tracked by computer audit and entries I make may become part of the patient's medical record.
- I may revoke this authorization at any time by writing: Boone County Hospital, Health Information Management, 1015 Union St, Boone, IA 50036. I understand that such a revocation will not have any effect on any information already released to my proxy. I understand access is provided as a convenience and Boone County Hospital may deactivate access at any time for any reason. I understand use of Health Portal is voluntary.
- By signing below, I acknowledge I have read and understand this form and acknowledge I am approving proxy access to my information. Additional instructions and terms and conditions are available on the Health Portal.
- I may refuse to sign this authorization and understand that my refusal to sign will not affect my ability to obtain treatment. If I refuse to sign this authorization, access to my health portal account will not be granted.

Signature of Patient/Authorized Person: _____ Date: _____

Staff Use Only: Boone ___ Ogden ___ Madrid ___ CSC ___ Home Health ___Hospital ____ Initials___