Fort HealthCare For Health	Consent MyCompass Adult Proxy Authorization Release of Information Consent

This consent is an authorization that will permit Fort HealthCare and other providers who use the Fort HealthCare electronic medical record to release your medical information to your designated adult proxy.

Your name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

I understand that:

- Authorizing proxy access will allow the person named below access to my personal health information through MyCompass. This form does not authorize release of my medical records to my designated proxy by other methods or in other forms.
- If I no longer wish this individual to access my information, it is my responsibility to revoke their access.
- A written request must be made to revoke this proxy access, and any actions taken or accesses made prior to that revocation were authorized as part of the initial signature and date.
- All activities within my MyCompass account may be tracked by computer audit, and entries my proxy makes may become part of my medical record.
- Access to a MyCompass account is provided as a convenience, and access to my MyCompass account may be revoked at any time for any reason, including unauthorized or inappropriate actions made by my proxy.
- Use of MyCompass is voluntary, and I am not required to use MyCompass or to authorize another person (proxy) to access my MyCompass account.
- My ability to obtain treatment, payment or other services will not be affected if I choose not to provide proxy access to my MyCompass account. However, I also understand that if I do not provide authorization, access to my MyCompass record will not be granted to my proxy.
- I authorize the use and/or disclosure of electronic protected health information (ePHI) through MyCompass as described below.
    - Names or classes of organizations authorized to release the ePHI through MyCompass:
        - Fort Memorial Hospital

  - Fort Medical Group
  - Health care provider using Fort HealthCare electronic medical record
- Description of ePHI to be released: health information available in MyCompass
- The ePHI is being disclosed for my proxy to have a more active role in my health care

- The authorization permits access to any care provided prior to the date of the authorization as well as any care and treatment provided while the authorization is valid.

- I understand that my proxy will have access to records that may include information relating to the diagnosis and/or treatment of mental illness, alcohol/drug abuse, STDs, HIV test results, developmental disabilities and genetic testing results.

- I understand that once information has been disclosed, the proxy may further disclose my ePHI and it may no longer be protected by federal law.

- By signing below, I acknowledge that I have read and understand the authorization, and I agree to its terms and grant proxy access to my personal health information via MyCompass to the individual named below.

Proxy Name: _____ Relationship: _____

Proxy Date of Birth: _____ Proxy Phone #: _____

Proxy E-Mail Address: _____

_____ _____

Patient (or representative) signature **Date**