MyFHN Patient Portal

PROXY APPLICATION AND AUTHORIZATION FORM

For your security and privacy, complete this form and submit in person to any FHN Healthcare facility.

- A proxy is a person who can access a patient's information as if they were the patient through the MyFHN Patient Portal.
- This form is to establish a MyFHN Patient Portal Proxy account which permits the authorized individual access to my patient records through the MyFHN Patient Portal.
- A patient must be an adult (18 years or over) or an emancipated minor to request a MyFHN Patient Portal login without granting parent/guardian proxy access. FHN does not provide MyFHN Patient Portal access to un-emancipated minors.

1. Patient Information:

Patient Last Name _____ First Name _____ Middle In _____

Address _____

Medical Record # _____

Email _____

Birthdate _____ Daytime Phone Number _____

Primary Physician _____ Primary Practice _____

2. Proxy Information (Person wishing to access patient information by proxy)*

Proxy Last Name _____ First Name _____ Middle In _____

Address _____

Medical Record # _____

Email _____

Birthdate _____ Daytime Phone Number _____

Do you have an active MyFHN Patient Portal account?
___ Yes
___ No

Have you been a patient at any FHN facility?
___ Yes
___ No

Relationship to Patient:
___ Custodial Parent
___ Non-Custodial Parent
___ Legal Guardian **
___ Spouse/Significant Other
___ Durable Power of Attorney for Healthcare (DPOA) **
___ Other

*Proper ID must be validated and scanned with this application.
**This request must be accompanied by a copy of legal paperwork verifying the individual's status as legal guardian.

We're here, for you.
FHN

PLEASE REVIEW THE FOLLOWING FHN PROXY AUTHORIZATION CAREFULLY.

BY SIGNING THIS FORM, I ACKNOWLEDGE AND AGREE:

I understand that the use of the MyFHN Patient Portal and the naming of any authorized individual proxy are optional and voluntary.

I understand the protected health information that I am authorizing to be released is privileged and confidential and may be disclosed only upon my consent except as permitted by law.

I authorize the release of my protected health information and medical records to allow the individual proxy named on this form to access this information through the MyFHN Patient Portal.

I understand and specifically authorize the disclosure of the following types of information to my authorized proxy through the MyFHN Patient Portal: Medication and allergy lists, immunizations, lab and pathology reports, radiology films, images and reports.

SENSITIVE INFORMATION:

In addition to the information above, I understand and specifically authorize the use and/or disclosure of the following types of sensitive information to my authorized proxy through the MyFHN Patient Portal: information regarding mental illness or developmental disability, outpatient counseling or psychotherapy services, sexually transmitted diseases (STD's), genetic testing, sexual assault, birth control, pregnancy, substance (i.e. alcohol or drug) abuse, and HIV/ Acquired Immune Deficiency Syndrome (AIDS) testing or treatment (including the fact that an HIV test was ordered, performed or recorded, regardless of whether the results of such tests were positive or negative).

I understand that if I do not want my authorized proxy to have access to ALL of the types of information listed above through the MyFHN Patient Portal, I should not sign this form. This form only concerns the release of information through the MYFHN Patient Portal. This authorization does not authorize the release of protected health information to the authorized proxy by any means other than the MyFHN Patient Portal.

I have the right to inspect and copy the information that is requested to be released pursuant to this authorization.

I understand that activities and entries made through the MyFHN Patient Portal by authorized proxy may become part of my permanent medical record.

I understand that this authorization permits access to information about care I have received in the past as well as care I may receive in the future for as long as this authorization is valid.

REVOCATION:

I understand that I may revoke this authorization in writing at any time, except to the extent information was released or other action taken in reliance on it. Any written revocation must be signed by the patient or legal representative, witnessed, and delivered to Medical Records Department, FHN, 1045 W. Stephenson, Freeport Illinois, 61032. I understand that I may orally revoke my consent for the release of information related to any state or federally assisted drug and alcohol abuse programs, but that FHN encourages patients to submit a written revocation in these circumstances as well to assist FHN in documenting and complying with a patient's wishes. Any revocation of this authorization will not be retroactive to information already released.

REDISCLOSURE:

Any user of the MyFHN Patient Portal should note that state and federal laws may restrict further disclosure of protected health information made available through the MyFHN Patient Portal. However, I understand that information released under this authorization might be further disclosed by my authorized proxy and that information my authorized proxy may further disclose may not be subject to privacy or confidentiality protections.

REFUSAL:

I understand that I may refuse to sign this authorization, and represent that no person has coerced or imposed any inappropriate conditions on my providing this authorization. I understand that if I do not sign this authorization, my authorized individual will not be provided proxy access to my protected health information through the MyFHN Patient Portal. I understand that if I am under the age of 18 and I have not provided legal documentation to FHN demonstrating that I am an emancipated minor, I may not establish a MyFHN Patient Portal account to obtain my information except by the completing the Release of Information process with my healthcare facility. I understand that my authorization of this form and/or my use of the MyFHN Patient Portal is not a requirement for treatment, and does not impact payment terms or influence enrollment/eligibility for health plan benefits.

RELEASE:

I hereby release and hold harmless FHN, FHN Memorial Hospital, affiliated organizations, clinics, behavioral health and other centers and their respective staff, providers, directors, officers, employees, agents, successors assigns and attorneys, from and against any and all liability, damages, claims, or suits, including reasonable attorneys' fees, in connection with the disclosure or use of my protected health information as identified on this form and in connection with the use of the MyFHN Patient Portal. If I am signing this form as a parent/guardian or authorized proxy I make this release on behalf of myself and the patient.

I have read, understand and agree to the Terms and Conditions of Use of the MyFHN Patient Portal. The Terms and Conditions of Use are available at any FHN Healthcare facility and through https://www.fhn.org/.

I understand the MyFHN Patient Portal may not be used to communicate urgent or emergent messages.

I understand the MyFHN Patient Portal may be deactivated or discontinued by FHN at any time, including as a result of unauthorized or inappropriate use by any individual.

I represent that all of the information provided on this form is true and correct.

Signature of Patient _____

Date _____

Signature of Witness _____

Date _____

Signature of Parent/Guardian/Authorized Proxy:

_____

Date _____

PARENT/GUARDIAN PROXY ACCESS TO RECORDS OF A PATIENT 12-17 YEARS OLD

I understand that the information in my health record may include information related to sexually transmitted disease, and acquired immunodeficiency syndrome/human immunodeficiency virus. It may also include information related to behavioral or mental health services and treatment for alcohol/drug abuse if present in my past or future record.

_____ (minor's initials)

Signature of Minor Patient_____

Date _____

Signature of Witness _____

Date _____

Signature of Parent/Guardian/Authorized Proxy:

_____

Date _____