Instructions for Completing Patient Portal Proxy Access Authorization Form

This form will authorize giving an individual (Proxy) acess to medical information contained in another person's (Patient) Patient Portal ("Portal").

Section 1 fill in the name, birth date, address, phone number, and email of the patient whose Portal will be accessible by the proxy ("Patient").
Section 2 fill in the name, birthdate, address, phone number, and email of the individual ("Proxy") who will access medical information that is available in the Portal.
Section 3 specify the relationship between the Proxy and the Patient. There must be no court orders or restraining orders in effect prohibiting the Proxy's right to have access to the Patient's medical records. **The person completing this form must fall within one of the following categories for access to be granted to the Portal:**

- Adult Patient who has the authority to grant others access to their medical information; or
- Patient advocate of an adult Patient under an activated Durable Power of Attorney for Health Care; or*
- Court-appointed guardian of an adult Patient; or*
- Court-appointed guardian of a minor Patient; or*
- Parent (non-foster parent) with legal rights to make important decisions on behalf of a minor (under 18 years old) Patient; or
- Foster parent of a minor (under 18 years old) Patient. *

**These relationship statuses require that the individual signing the form provide legally valid paperwork confirming the individual's authority to access the Patient's medical information.*
Section 4 read the terms and conditions of granting the Proxy access.

PLEASE NOTE: By signing this form, both the Patient and Proxy understand and agree that:

1. **The information available in the Portal may include, but is not limited to, the diagnosis and/or treatment of mental illness, substance use disorder treatment and medication assisted treatment, sexually transmitted infections (including HIV or AIDS test results), developmental disabilities and genetic testing results.**
2. The Proxy is not covered under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and may not be subject to federal or state privacy laws. Information disclosed to the Proxy may no longer be protected by federal or state law.
3. When the Proxy's authority to access the patient's medical records has been inactivated, revoked, terminated, or expired, the Proxy will no longer access the Patient's Portal and will immediately notify Lansing Pediatrics in writing of the change in authority by mail, fax or email.
4. **If the individual signing the form is the Minor Patient, the information available in the Portal may include medical records for the treatment of the Minor Patient consented to on their own, including but not limited to, outpatient mental health care, prenatal and pregnancy-related care, substance use disorder treatment, and sexually transmitted infections (including HIV and AIDS testing results).**
5. If the individual signing the form is the **Parent (non-foster)** or **Foster Parent of a Minor Parent:**
    a. Communications on behalf of the Minor through the Portal must be sent from the Minor's Portal and responses will be received in the Minor's Portal.
    b. When the minor reaches age 12, the Proxy will be granted full access to the Patient's Portal. On the minor's 18th birthday, or upon the Patient removing the Proxy from the Portal access at any time, the Proxy's access will be turned off.
    c. The Proxy will be using their own Portal account to access the Minor's Portal account.
    d. The individual signing the form has the legal right to access the Minor's medical records.
    e. There are no court orders or restraining orders in effect prohibiting the Proxy's access to the Minor's medical records.
6. If the individual signing the form is the **Patient Advocate** or **Court-Appointed Guardian,** documents provided in support of the Proxy's right to access the Patient's right to access the Patient's medical records are true and correct and are the most recent documents.

PLEASE SUBMIT THIS FORM TO LANSING PEDIATRIC ASSOCIATES BY MAIL, FAX OR IN PERSON:

Lansing Pediatric Associates
2414 Lake Lansing Road
Lansing, MI 48912
Phone: (517) 371-4712
Fax: (517) 371-xxxx

Patient Portal Proxy Access Authorization

1. Patient's Information:

Patient's Name: _____ Date of Birth: _____
Last First Middle Initial

Address: _____
Street Address City State Zip Code

Phone Number: _____ Email Address: _____

2. Proxy's Information:

Proxy Name: _____ Date of Birth: _____
Last First Middle Initial

Address: _____
Street Address City State Zip Code

Phone Number: _____ Email Address: _____

3. Relationship of Individual Requesting Proxy Access to the Patient's Portal:

- ☐ I am the Parent (non-Foster) with legal rights to make decisions on behalf of the MINOR (over 12 years old) patient
- ☐ I am the Foster Parent of the MINOR (over 12 years old) patient*
- ☐ I am the Court-Appointed Guardian of the MINOR patient*

**Requires legally valid paperwork confirming authority to access the Patient's medical information*

4. Terms and Conditions of Proxy Authorization: By signing this form, I (the patient or Patient's legal representative):

- **a.** I authorize Lansing Pediatric Associates and its affiliates to disclose any of the Patient's medical information which is available in the Portal to the Proxy. I understand this includes medical information created by providers within Lansing Pediatric Associates related to substance abuse disorder treatment and medication assisted treatment.
- **b.** I understand that I may refuse to sign this form and that my refusal to sign will not affect the Patient's ability to obtain treatment. If I refuse to sign, access to the Patient's Portal by the Proxy will not be granted.
- **c.** I understand that I can revoke (cancel) the Proxy's access to the Patient's Portal at any time by providing written notice to Lansing Pediatric Associates. Revoking the Proxy's access will not have any effect on any actions taken in reliance on the authorization granted in this form or on any medical information already released to the Proxy.

BY SIGNING BELOW, THE PATIENT OR PATIENT'S LEGAL REPRESENTATIVE ACKNOWLEDGES AND AGREES: If there is medical information that should not be shared with the Proxy, I should not sign this form.

_____ _____ _____
Patient or Legal Representative Signature **Name** **Date**

BY SIGNING BELOW, THE PROXY ACKNOWLEDGES AND AGREES: The Proxy will not redisclose any information accessed through the Patient's Portal if such redisclosure is prohibited by federal or state law.

_____ _____
Proxy Signature **Date**

Completed by: _____ _____
Staff Signature **Print Name** **Date**