Holy Family Memorial
Sponsored by the Franciscan Sisters of Christian Charity

Proxy Request Form—Adult's DPOA/Permanent Legal Guardian

Complete this form if you are the permanent legal guardian or the activated durable power of attorney for healthcare for the patient and would like to either:

- Grant yourself proxy access to access the patient's electronic health record through Holy Family Memorial's patient portal, My Personal HFM Record; or
- Grant someone else proxy access to access the patient's electronic health record through Holy Family Memorial's patient portal, My Personal HFM Record.

Patient Name (print): _____ Date of Birth: _____

Medical Record Number: _____ Phone Number: _____

Address: _____

I authorize the use and/or disclosure of the above-listed patient's electronic protected health information ("ePHI") through Holy Family Memorial's patient portal, My Personal HFM Record, for purposes of overseeing the patient's care. By signing this access form, I am attesting to having legal rights to access this patient's record as described below.

I understand access will include electronic health information that may have been created at the medical center or at a clinic site, which is part of the Holy Family Memorial Network.

Name and address of the person authorized to participate in Holy Family Memorial's Patient Portal as the patient's proxy:

Proxy's Name (print): _____ Date of Birth: _____

Address: _____

Phone Number: _____ Email: _____

My Relationship to the patient is as follows:

☐ Permanent Legal Guardian of the Patient—Proxy must attach a copy of the Court Order Appointing Guardian and Letters of Guardianship verifying the Proxy's status as permanent legal guardian of the patient.

OR

☐ Activated Durable Power of Attorney for Healthcare (DPOA)—Proxy must attach a copy of the valid Durable Power of Attorney for Healthcare and two Physician Certifications verifying the patient lacks decisional capacity.

This authorization is effective until the patient's My Personal HFM Record account is inactivated, this authorization is terminated in writing as described below, or my legal authority to act on behalf of the patient has been inactivated, revoked, terminated, or expired, whichever occurs first. If none of the above events occur, access to the patient's ePHI through My Personal HFM Record will expire 3 years from the date of signature below. I will then need to complete this form again to authorize

access for another 3 years. This authorization permits the release of records that were created or existing on or before the date this authorization was signed, as well as records that are created after the date this authorization is signed and up to the date of termination or expiration of this authorization.

I understand that the information to be released 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. If you do not wish for any or all of these types of sensitive information to be shared, you should not complete this form. The system is unable to exclude certain types of information from proxy access.

I understand that I have a right to terminate this authorization at any time. If I want to terminate this authorization, I must do so in writing and mail to: Holy Family Memorial, Inc., HIM Department, 2300 Western Avenue, P.O. Box 1450, Manitowoc, WI 54221-1450. I understand that the termination will not apply to information that has already been released.

I understand that Wisconsin Administrative Code §§ DHS 92.05 and 92.06 grant patients the right to inspect and/or receive a copy of certain health records. I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned upon execution of this authorization. I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by applicable law. However, information subject to 42 CFR Part 2 may not be re-disclosed pursuant to this authorization unless an exception applies.

A photocopy/facsimile copy of this completed form is as valid as the original document.

Proxy's Signature: _____ Date: _____

Relationship to Patient: _____

Notice to recipients of information pursuant to this authorization:

If this information has been disclosed to you from substance use disorder records protected by federal confidentiality rules (42 CFR part 2), federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). Federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.