Holy Family Memorial
Sponsored by the Franciscan Sisters of Christian Charity

Proxy Request Form-Child Age 12-17

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

Medical Record Number: _____ Phone Number: _____

Address: _____

I request and authorize the use and/or disclosure of my electronic protected health information ("ePHI") through Holy Family Memorial's patient portal, My Personal HFM Record, to my parent/legal guardian identified below for purposes of overseeing my care.

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 parent/legal guardian authorized to participate in Holy Family Memorial's Patient Portal as my proxy:

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

Relationship to Patient: _____

Address: _____

Phone Number: _____ Email: _____

This authorization is effective until the date My Personal HFM Record account is inactivated, the date I revoke this authorization in writing as described below, or the date I reach age 18, whichever occurs first. 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 revocation or expiration of this authorization. Upon turning 18, I understand I will need to complete a different proxy form that takes into account his or her legal rights as an adult.

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 revoke this authorization at any time. If I want to revoke 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 revocation 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.

Signature of Patient: _____ Date: _____

Proxy Attestation and Acknowledgment

I attest that I have parental rights or legal guardianship rights to access this child's record. I attest that I have not been denied periods of physical placement with the above-named child. I acknowledge that I have read the above and understand what proxy access entails, the limitations, and the patient's right to revoke my access at any time. By signing below, I acknowledge acceptance of such proxy access to the above-named patient's My Personal HFM Record.

Signature of Proxy: _____ Date_____

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.