PennState Health
Milton S. Hershey Medical Center

MY PSH HEALTH PROXY AUTHORIZATION

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Address: _____ PSHMC Medical Record Number: _____

_____ Phone: _____

Cell: _____

PARENT/GUARDIAN/HOME CAREGIVER INFORMATION

Name: _____ Date of Birth: _____

Relationship to patient: ☐ Birth Parent ☐ Adoptive Parent ☐ Legal Guardian ☐ Other:
(Check medical record for documentation of designated representative; If none, then follow prioritization defined in L07 HAM, "INFORMED CONSENT" (http://infonet.hmc.psue.edu/policy/HospitalAdmin/L-07-12_Informed_Consent.docx))
Documentation establishing relationship may be requested.

Address: _____

_____ Phone: _____

_____ Cell: _____

Please provide e-mail address for MyPennStateHersheyHealth to notify the Proxy listed above for account activation and management:

By signing below, Proxy agrees to these terms:

- I will use my own user ID and password to access My Penn State Hershey Health.
- I will not share my user ID and password with anyone.
- I will abide by the terms and conditions of the My Penn State Hershey Health site.
- Access to a patient age 14 – 17 online medical record will end for the patient, parent and guardians on the patient's 18th birthday, and any further access must be requested at the PSHMC clinic or community practice site.

Proxy Authorization: I certify that I have the relationship indicated above, to the patient named above. I understand that this patient has granted me continued proxy access to his/her personal health information through My Penn State Hershey Health. I further understand that the patient may revoke this access at his/her discretion by notifying my clinic or community practice site in person or in writing.

_____ _____
Parent/Guardian signature Date

If patient lacks Decision Making Capacity (DMC) as defined in L-15 HAM, "PROCEDURE FOR OBTAINING COURT ORDER FOR TREATMENT OF A MINOR OR INCOMPETENT ADULT" (http://infonet.hmc.psu.edu/policy/HospitalAdmin/L-15-11_Procedure_for_Obtaining_a_Court_Order.docx), the provider should document the impairment in the medical record, and sign here:

_____ _____ _____
Provider Name (Please Print) Provider Signature Date

_____ _____ _____
Witness Name (Please Print) Witness signature Date

Patient Authorization: I agree to allow the "Parent/Guardian/Adult Proxy"above to have access to my online medical record information, including information that may become available as a result of future medical care. I understand that I may revoke this access at any time by notifying my clinic or community practice site in person or in writing.

_____ _____
Patient signature Date

MY PSH HEALTH PROXY AUTHORIZATION