ST. ANTHONY MyeChart

MANNING REGIONAL HEALTHCARE CENTER
An Affiliate of MERCYONE

Authorization for Proxy Access to My eChart Agreement

This form must be completed, signed and returned to request access to My eChart to help manage the medical care of a patient 13 years of age and older.

Patient Information: (Please print)

Name: _____ Date of Birth: _____

Address: _____

Proxy Information (Person requesting access to My eChart): (Please print)

I authorize the following individual to participate in My eChart as my proxy:

Name: _____

Email Address: _____

(Please supply the email address of the person who will be using My eChart)

I understand that my proxy will have the same access and privileges that I have for My eChart. I understand that this allows my proxy online access to all of my personal health information, including any mental health information, HIV/AIDS information, and substance abuse information that may be included in my medical records at St. Anthony Regional Hospital and Manning Regional Healthcare Center. My proxy will be able to view portions of my record that I am able to view. I also understand that additional information may be made available to my proxy through My eChart as St. Anthony Regional Hospital and Manning Regional Healthcare Center continue to implement this product.

By signing this authorization, I am requesting St. Anthony Regional Hospital and Manning Regional Healthcare Center give access to my proxy to utilize My eChart. I understand that St. Anthony Regional Hospital and Manning Regional Healthcare Center will require my proxy to sign an acknowledgment and agree to St. Anthony Regional Hospital and Manning Regional Healthcare Center policies and procedures for use of the patient portal.

I understand that St. Anthony Regional Hospital and Manning Regional Healthcare Center may not condition treatment or payment actions on whether I sign this authorization.

This authorization is valid until revoked by me or upon my death. I understand that a written request is necessary to revoke or cancel this authorization, but in the case of death, this authorization will automatically expire. In order to revoke or cancel my authorization I must send such request in writing to St. Anthony Regional Hospital, ATTN: ANALYSTS, 311 S. Clark St., Carroll, IA 51401. However, I understand that my revocation will not be effective as to uses and/or disclosures already made in reliance upon this authorization. I realize that the information used and/or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy laws.

I acknowledge that a copy of this signed authorization has been provided to me.

Patient Acknowledgment

_____ _____

Signature of Patient Date

Proxy Acknowledgment

_____ _____

Signature of Proxy (Individual requesting access) Date

If Mailing Return Completed Form to: **St. Anthony Regional Hospital, ATTN: ANALYSTS, 311 S. Clark St., Carroll, IA**