Northern Arizona Healthcare

MyNAHealthcare Patient Portal Proxy Access Request & Authorization

Designating a Proxy

Northern Arizona Healthcare (NAH) patients can give another person the right to see their NAH medical record. Proxy access gives the person that you name (your "Proxy") (i.e., parent, legal guardian, or other elected adult) the ability to view your medical record information and talk with your health care providers using the MyNAHealthcare Patient Portal. Patient information viewed by your Proxy may include your medications, immunizations, procedures, lab results, microbiology results, radiology (X-ray) reports, pathology results, and visit and discharge summaries. Please note: You or your proxy may revoke Proxy access at any time. See sections 4 and 5 for instructions. **To request a proxy, send this completed form, copy of the patient's photo ID, and required documentation to patientportal@nahealth.com**.

1. **Patient Information** (Complete all information. Please write or print clearly.)

Patient Name: _____ **Date of Birth:** _____
Last First M.I.

Address: _____ **Medical Record Number:** _____
Street Address City, State Zip (optional)

2. **Proxy Information** (Person to whom you authorize NAH to allow access to your MyNAHealthcare Patient Portal account. Complete all information.)

Revoke an existing Proxy's access ☐

Proxy Name: _____ **Date of Birth:** _____
Last First M.I.

Address: _____ **Phone Number:** _____
Street Address City, State Zip

Email Address: _____

3. **Please check one of the boxes below that best describes the proxy access requested.** (Please note that for all types of proxy access, the patient's information will be accessed through the proxy's own patient portal account.

Adult Patient

An adult competent patient may select a person to be their proxy. An emancipated minor shall be treated as an adult for purposes of this form. An emancipated minor patient must provide proof of emancipation.

Relationship of Proxy to Adult Patient is:

☐ Spouse, family member or other (Photo ID, required).

Specify relationship: _____
Examples: Wife, Sibling, Friend, Neighbor

☐ Legal representative of patient (Adults who have a surrogate relationship with another adult through a legal agreement).

Which option best describes this representative's relationship?

☐ Power of Attorney for Healthcare (Documentation of current authority, required)

☐ Legal guardian (Documentation of current court order, required)

Minor Patient

Individuals requesting access must have parental or permanent legal guardianship rights.

- For a child aged 0 to 12 years, Proxy will be granted full access to the child's patient portal record.
- Proxy access will automatically terminate on the minor's 13 birthday.

Relationship of Proxy to Minor Patient is:

☐ Parent (Birth certificate, required)

☐ *Permanent legal guardian of the minor (A copy of a court order appointing guardianship to verify the Proxy's status, required.)

*Proxy access cannot be granted to temporary guardians. Contact the NAH Health Information Management (HIM) department for assistance.

Flagstaff Medical Center HIM: 928-773-2072
Verde Valley Medical Center HIM: 928-649-6280

4. By signing below, proxy acknowledges and agrees that:

- If the patient is a minor, I am attesting to having parental rights to access the patient's records.

- Any documents I have provided in support of my right to access the patient's protected health information are true and correct copies and are the most recent documents related to this matter.

- I have not been denied periods of physical placement with the patient and there are no court orders or restraining orders in effect limiting my access to this patient's medical records and/or information.

- Communications on behalf of the patient may be sent and received through the patient's MyNAHealthcare Patient Portal account. Patient portal e-mail alerts will be sent to the e-mail address entered under Parent/Legal Guardian ("Proxy") Information.

- **When my legal authority to act on behalf of the patient has been inactivated, revoked, terminated, or expired, or I no longer wish to serve as proxy, I must immediately notify NAH by submitting a new copy of this form.** (Complete sections 1, 2, and 4. Be sure to check "Revoke" in section 2 before submitting to patientportal@nahealth.com.)

Proxy: By signing below, I acknowledge and agree to comply to the terms and conditions of this authorization agreement:

_____	_____	_____	_____
Date (Required)	Time	Proxy Printed Name (Required)	Proxy Signature (Required)

5. By signing below, patient acknowledges and agrees that:

- I understand I am giving Northern Arizona Healthcare permission to disclose my protected health information to my proxy. Information may include but is not limited to: health summary, problem lists, medications, lab results, appointment information.

- Sensitive information may be available to my proxy, including but not limited to (1) Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, (2) treatment for drug or alcohol abuse, (3) sexually transmitted diseases, (4) sexual orientation, or (5) mental or behavioral health or psychiatric care.

- My proxy may view records that were created or existing on or before the date this form was signed and will include records that are created after the date this form is signed.

- **I have a right to revoke this authorization at any time**. I must do so by submitting a new copy of this form, and I understand that such a revocation will not affect any information already released to my proxy. I understand my proxy may continue to access my information until such revocation occurs. (Complete sections 1, 2, and 5. Be sure to check "Revoke" in section 2 before submitting to patientportal@nahealth.com.)

- I understand that the information disclosed by this authorization could be re-disclosed by my proxy and no longer protected by federal or Arizona state privacy laws.

- I may refuse to sign this authorization and understand that my refusal to sign will not affect my ability to obtain treatment. If I refuse to sign below, access to my patient portal account will not be granted to my proxy.

Patient/Parent(s)/Legal Guardian: By signing below, I acknowledge and agree to comply to the terms and conditions of this authorization agreement:

_____	_____	_____	_____
Date (Required)	Time	Patient Printed Name (Required)	Patient Signature (Required)