Mary Rutan
HOSPITAL
205 E. Palmer Rd., Bellefontaine, OH 43311
Phone: 937-599-7026

Office Use Only
MR_____
Acct#_____
Prepared by:_____
Date:_____
Released by:_____
Date:_____

AUTHORIZATION TO GRANT ACCESS TO MEDICAL RECORD AND TO MYCARE PORTAL

If you are 18 years of age or older and would like another adult to access your medical information (i.e. "Proxy"), then you, as the patient, should complete this form.

Section I: IDENTIFY PATIENT'S INFORMATION
Patient's Name (First, MI, Last):
Patient's Medical Record #:
Patient's Date of Birth:
Patient's Address: City: State: Zip Code:
Patient's Telephone Number:
Section II: IDENTIFY PROXY'S INFORMATION
Name of Proxy:
Proxy's Date of Birth:
Proxy's Address:
Proxy's Telephone Number:
Proxy's E-mail Address:
Proxy's Relationship to Patient:

Initial here if you want to grant your Proxy access to your MyCare Portal: _____

By initialing here, I am requesting Mary Rutan Hospital to give access to my Proxy to utilize the MyCare Portal. I understand that my Proxy will have the same access and privileges that I have for the MyCare Portal. I understand that this allows my Proxy online access to my personal health information. 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 the MyCare Portal as Mary Rutan Continues to implement this product. I understand that Mary Rutan Hospital may require my Proxy to sign an acknowledgment and agree to Mary Rutan Hospital's policies and procedures for use of the MyCare Portal.

Section III: Release – Please Read Carefully

I understand that medical information is contained in my medical record and in MyCare Portal. This may include personal and private information and results of tests and treatments I have had. I know that my Proxy could share any information that is in my medical record or on MyCare Portal. I know there may not be laws that protect my privacy in this case. I know that this authorization also grants the identified individual with access to MyCare Portal. **I know that this access does not grant legal representation for my health care.**

I hereby authorize Mary Rutan Hospital, including healthcare providers listed in the Notice of Privacy Practices, and its employees to release the information contained in my medical record. I understand and acknowledge that this authorization may include treatment for physical and mental illness, alcohol and/or drug abuse, and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include results of a HIV test or the fact that an HIV test was performed. A separate authorization is required for the release of psychotherapy notes.

This authorization is valid until revoked by my written notice, provided said notice is received prior to release of information contained in my medical record. **The revocation of this authorization is effective except as indicated in Mary Rutan Hospital's Notice of Privacy Practices. Information released by this authorization may no longer be protected by federal privacy rules, such as HIPAA.** I understand that Mary Rutan Hospital cannot condition my treatment or payment for health care on this authorization unless the treatment is research related or the care was provided solely to provide information for a third party. I know that I can stop or change my Proxy at any time. I can stop access by sending a written request to: Attn Medical Records, Mary Rutan Hospital, 205 East Palmer Road, Bellefontaine, OH 43311. If you have any questions, please call 937-599-7026. I must sign a new authorization form each time I want to give another person access to my medical record.

Signature of Patient: Date/Time: