St. Luke's MyCare Proxy Consent Form

The St. Luke's MyCare patient portal provides online access to patient information, which may include the problem list, allergies, medications, lab and radiology results, and other clinical information. By using St. Luke's MyCare this information can be accessed at your convenience.

To grant/request access to another person or to your child's information, please complete the information below

Patient's Information- whose medical record will be shared?

Patient Name: _____ DOB:_____

Phone #: _____ Email Address:_____

Street Address:_____ City:_____

State: _____ Zip:_____ Portal username *(if known)*: _____

Full access to another adult's information will be granted with written consent from the patient. If the individual has diminished capacity, full access will be granted to the patient's legally authorization representative.

For minors 12 to 17 years old, this authorization MUST be filled out by the patient for parents/legally authorized representative to have proxy access to the patient portal. This is based on Minnesota Statute 144.343 which allows minors to independently consent to evaluation and treatment of certain conditions. The authorization expires when the patient turns 18 years old.

I authorize the following individual to participate in St. Luke's MyCare Patient Portal as my proxy.
Proxy's Information- who can access the patient's medical record?

Name: _____DOB:_____Relationship to Patient:_____

Phone #: _____ Email Address:_____

Street Address:_____ City:_____

State: _____ Zip:_____ Portal username *(if known)*:_____

I understand that my proxy will have the same access and privileges that I have for the Patient 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 patient portal as St. Luke's continues to implement this product.

This authorization is valid for 2 years or until revoked by me. I understand that a written request is necessary to revoke or cancel this authorization. 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.

Patient Acknowledgment	**Proxy Acknowledgment**
_____	_____
Signature of Patient (Required for patients 12 and older), Date	Signature of Proxy, Date

Legal decision maker authorization is required, in addition to the minor patient (age 12-17) when proxy access is granted to someone other than the legal decision maker.

_____ _____

Parent/Legally Authorized Representative Signature, Date Printed Name

Please return the completed form to:

St. Luke's
Medical Records-Patient Portal
915 East First Street
Duluth, MN 55805

Phone: (218) 249-2003
Fax: (218) 249-3076
Email: portalforms@slhduluth.com

Please allow 10 business days for processing.

Internal Use Only
Date Received:_____ Staff Initials: _____

ID Verified: Y/N Date Processed: _____