ASPIRUS ST. LUKE'S

ASPIRUS LAKE VIEW

Aspirus St. Luke's MyCare Proxy Consent Form

An Aspirus St. Luke's myCare Patient Portal account provides online access to patient information and medical records, which may include the Problem List, allergies, medications, lab and radiology results, and other clinical information. Fill out this form to grant account access to another person (a Proxy) or to request proxy access to a child's account.

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

Patient Name: _____ DOB: _____

Phone #: _____ Email Address: _____

Street Address: _____ City: _____

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

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)*: _____

For Patients 12 and under, those with diminished capacity, or minor patients whose proxy is not their legal decision maker:

_____ _____ _____

Signature of Parent/Legally Authorized Representative | Date | Printed Name

For Patients 12 and older:

I authorize the above individual to participate in Aspirus St. Luke's myCare Patient Portal as my proxy.

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 Aspirus St. Luke's continues to implement this product.

This authorization is valid for 2 years unless revoked by me sooner. 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

_____

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

Proxy Acknowledgment

_____

Signature of Proxy, Date

***** For patients 12 years of age and up, access can only be granted with written consent from the patient by their filling out this form (this includes parental access to their minor child's portal information, per Minnesota Statute 144.343, which allows minors to independently consent to evaluation and treatment of certain conditions. The proxy authorization expires when the patient turns 18 years old). Legal decision maker authorization is also required, in addition to the minor patient (age 12-17), when proxy access is granted to someone other than the legal decision maker.

If the patient has diminished capacity, no patient signature is required, and full access will be granted to the patient's legally authorized representative.

Please return the completed form to:

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

Phone: (218) 249-2003
Fax: (218) 249-3076
Email: asl-portalforms@aspirus.org

Once your request has been processed, you will receive an email with instructions on how to access the account. Please allow 10 business days for processing.

Internal Use Only
Date Received:_____ Staff Initials: _____

ID Verified: Y/N Date Processed: _____