MySecureHealthData.com Adult Proxy form

To sign up for access to the health information of an adult whose health care you help manage, please complete this form and return it to the address shown below. Please note that the patient's chart will be accessed through your (the proxy's) MySecureHealthData.com account.

Return all forms to:

Richie Eye Clinic
1575 20th St NW, Suite 101
Faribault, MN 55021

or

Fax 507-209-6220

Your information: (all sections required – please print clearly)

This section should be completed by the individual requesting access to another adult's record.

Name (last, first, middle initial) ____

Street Address: ______________________________City:_____________State:____Zip:_____

Last 4 digits SSN: ___________________ Date of Birth:_________________________

Email address: ____________________________________ Phone Number:_______________

Patient's information: (all sections required – please print clearly)

Complete this section with information about the adult whose interactive health record you are requesting to access.

Name (last, first, middle initial) ____

Street Address: ______________________________City:_____________State:____Zip:_____

Last 4 digits SSN: ___________________ Date of Birth:_________________________

Email address: ____________________________________ Phone Number:_______________

MySecureHealthData.com terms and agreement

- I understand that MySecureHealthData.com is intended as a secure online source of confidential information. If I share my username and password with another person, that person may be able to view my or my child's health information, and health information about someone who has authorized me as a MySecureHealthData.com proxy.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe confidentiality may have been compromised in any way.
- I understand that it is my responsibility to ensure that my email address is current at all times, and that if my email address is not current, I will not receive important messages from MySecureHealthData.com.
- I understand that MySecureHealthData.com contains selected, limited medical information from a patient's health record and that MySecureHealthData.com does not reflect the complete contents of the health record. I also understand that a paper copy of a patient's health record may be requested.
- I understand that my activities within MySecureHealthData.com may be tracked electronically and that entries I make may become part of the medical record.
- I understand that access to MySecureHealthData.com is provided as a convenience to patients and that MySecureHealthData.com Services has the right to end access to MySecureHealthData.com at any time, for any reason.
- I understand that my use of MySecureHealthData.com is voluntary and I am not required to use MySecureHealthData.com or to authorize a MySecureHealthData.com proxy.

Your (proxy) signature	Relationship to patient	Date (required)
Signature of patient/authorized person	Relationship to patient	Date (required)