Hospital Sisters HEALTH SYSTEM

AUTHORIZATION TO ACCESS ONLINE MEDICAL RECORDS

This authorization form will enable access to the Hospital Sisters Health System (HSHS) Shared Electronic Health Record through the use of MyChart, as such Shared Electronic Health Record is described in the HSHS Notice of Privacy Practices. Multiple health care entities participate in the Shared Electronic Health Record. Such health care entities may change over time. Information on health care entities participating in the Shared Electronic Health Record is available on the HSHS health care websites or by contacting the HSHS or local health care Privacy Officer.

** I understand that My Chart is NOT to be used in an emergency.

Name of Patient _____ Date of Birth _____ Telephone Number _____

Patient Address - City/State/Zip _____

E-mail address for MyChart messages _____

I understand that MyChart is for access of personal information regarding myself or others whom I have been authorized by or for whom I am the legal representative. The purpose of MyChart is to allow me to play an active role in my health care or those whom I assist with their health care.

I am requesting authorized access under the following circumstances (for all items listed below, the individual being granted access must be listed).

- ❑ Access to my own record (adult age 18+)
- ❑ Access to my own record (minor age 12-17)
- ❑ Access to my child's record (minor age 12-17) consent must be signed by child
- ❑ Access to my child's record (minor under age 12)
- ❑ Access to records as a legal representative*
- ❑ Access to records of the above stated patient by an individual authorized by the patient or his/her legal representative*

Name & DOB of individual to have access to the record: _____ DOB_____

I acknowledge that I will only have access to information made available through MyHealth. **I ACKNOWLEDGE THAT SENSITIVE INFORMATION INCLUDING BUT NOT LIMITED TO HIV TEST RESULTS, STD TEST RESULTS, PREGNANCY, MENTAL HEALTH/BEHAVIORAL CARE, OR ALCOHOL AND/OR DRUG AND/OR SUBSTANCE USE (AODA/SUD) RELATED CARE ARE ALSO AVAILABLE TO THE INDIVIDUAL I HAVE NAMED ABOVE.** MyChart may not include all records that may be in possession of my health care provider.

I understand that if I would like a complete set of records I need to contact my health care organization.

I understand that my activities within MyChart are tracked by computer audits and the entries that I make will become part of the medical record of myself or the person whose health care I am authorized to participate in.

I understand that it is my responsibility to maintain my password in a secure manner and to change it if I feel that it has been compromised in any way.

I understand that by signing this agreement, I must provide my health care organization with documentation of my authorization to access protected health information of adults other than myself or those for whom I am serving as legal representative and/or certify that I am the parent of the person whose records I am seeking access.

I understand that information used or disclosed based upon access or those I have authorized to access may possibly be re-disclosed by the recipient, and/or no longer be protected by Federal privacy standards.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to be Used or Disclosed - I understand that I have a right to inspect or receive a copy (with possible fee) of the health information I have authorized to be used or disclosed by this form. I mayarrange to review or obtain copies of my health information by contacting my health care organization. **Right to Receive a Copy of This Authorization -** I understand that if I agree to sign this authorization, - I have been advised to retain a copy of it. Right to Refuse to Sign This Authorization I understand that I am under no obligation to sign this form. Treatment, payment, enrollment or eligibility for benefits may not be based upon my decision to sign this authorization, (Exceptions: To provide care that is done solely for the purpose of creating information to release to another party, in which case care cannot be provided without authorizing disclosure. Authorization is needed to release information to payers for certain mental health services and HIV testing. If I refuse to sign the authorization form for this purpose, I understand I may be responsible for paying the entire bill for these services). Right to Revoke This Authorization - I understand that I may revoke this authorization. A description of how to revoke the authorization and any exceptions are included in the Notice of Privacy Practices. This notice is available at my health care organization's website, as listed above, or at the patient registration desk. HIV Test Results - HIV results are protected under Wisconsin state statute 252.15 and the Illinois AIDS Confidentiality Act (410 ILCS 305 et seq) may not be disclosed without written informed consent/authorization, except to persons or organizations that have been given access by state law. A list of those persons/organizations is available upon request.

I understand that there is not a fee associated to accessing ChartMyHealth.

This authorization will not expire unless revoked by the patient or Legal Representative.

Date	Time	Signature of Patient if Age 12-17 Signature of *Legal Representative for all Others
State Relationship to Patient		If signed by Legal Representative - Print Name
Date	Time	Signature of Witness

Return completed authorization to HSHS facility or HSHS Epic affiliate site

A photocopy of this authorization will have the same force and effect as the original.

*** Legal Representative** means the parent; guardian; legal custodian of a minor patient; the guardian of a patient adjudged incompetent; a person authorized in writing by the patient; a health care agent designated under Wisconsin Chapter 155 and the Illinois Powers of For Health Care Law (755 ILCS 45/4-1 et seq) if properly activated; a temporary guardian appointed by a court to consent to release of health care records; the spouse, domestic partner or personal representative of a deceased patient, or if no spouse or domestic partner survives a deceased patient (and no personal representative), an adult member of the deceased patient's immediate family. A copy of the appointment as personal representative, guardian, or health care agent is required.