BUTLER MEMORIAL HOSPITAL

My BHS Health Proxy Access: Adult Authorization Form

Note: There will be one Agreement signed for each Proxy

Patient Information:

Patient Name: (Legal Name): Date of Birth:

Address Phone:

Medical Record Number: (Optional) Last four Digits of Social Security Number:

I DO want certain parts of my medical record as maintained by My BHS Health Record to be made available for viewing over the internet to the individual listed below as my "proxy'. I understand that information includes, but is not limited to, my: health summary, current problem list, current medications , lab results , and diagnostic/testing appointment information.

I am aware that my medical record may contain information related to: (1) acquired immune deficiency syndrome (A IDS) or human immune deficiency virus (HIV)· (2) treatment for drug and alcohol abuse; (3) sexually transmitted diseases, contraceptive use, or birth control; and (4) mental or behavior health treatment and *I* understand that some of this information may be visible to my proxy. For example, I understand that any medications l have been prescribed related to these conditions (if any) will be visible to my proxy.

I understand that I may make changes to permit or deny access to my proxy at any time and that these changes must be in writing and sent to BMH Medical Records Department, One Hospital Way , Butler, PA 16001 or faxed to BHS Medical Records at 724-284-4532. I also understand that I can change my proxy by completing the Proxy Expiration form and sending this to BHS Medical Records Department. I understand that it may take up to five (5) business days to receive and process my request to change my proxy and that any proxy already given access will continue to have access until this change is processed.

- By signing this proxy request, I understand that I am giving my permission for BHS to disclose my protected health information (PHI) through My BHS Health to my proxy.
- This proxy request includes records that were created or existing on or before the date this form was signed, as well as records that are created after the date this form is signed.
- I understand that I have a right to revoke this authorization at any time, and I understand the steps to do so as noted above. I understand that such a revocation will not have any effect on any information that was already released to my proxy.
- l understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Pennsylvania State privacy laws. I agree not to hold Butler Memorial Hospital or its affiliates, or their respective physicians, employees or agents responsible for any such re-disclosure by my proxy.

E - Signature of Patient:

Print name of Proxy who will have access to My Record Relationship to Patient:

Proxy's email address: