Gundersen Lutheran

MyCare Adult Proxy Authorization Form

1900 South Avenue, FBB-001, La Crosse, WI 54601
PHONE: (800) 362-9567, Ext. 53199 or (608) 775-3199 ● **FAX:** (608) 775-4706

Patient Name:_____ Date of Birth:_____

Patient Address:_____ Phone Number:___(___)_____

City/State/Zip:_____

I understand that MyCare is an Internet application that supports patient access to portions of my electronic healthcare record, electronic communications and other online services. I understand that MyCare is **NOT** to be used in an emergency.

I understand that authorizing proxy access will allow the person named below access to my personal health information. This authorization permits access to any care provided prior to the date of the authorization as well as any care and treatment provided while the authorization is valid. I understand that my proxy will have access to the following information about myself; this may include, but is not limited to:

- Laboratory results (that have been released based on my provider's discretion)
- Ability to communicate to my provider's care team regarding my care and treatment through MyCare
- Ability to review and request appointments
- Request renewals on my prescriptions
- View summary information about my medical history

The reason for this access authorization is for my proxy to play a more active role in my healthcare. I understand that additional information may be made available to my proxy through MyCare as this application advances.

I understand that all activities within MyCare are tracked by computer audit and that entries my proxy makes can become part of my permanent medical record.

I understand that this authorization will expire within two years, unless otherwise specified.

I understand that by signing this agreement I am providing Gundersen Lutheran documentation of my authorization to provide proxy access to my MyCare account. I understand that a written request must be made to revoke this authorization and that any actions taken or accesses prior to that revocation were authorized as part of the initial signature and date.

I understand that MyCare is optional/voluntary and that my provider has the right to deactivate access to MyCare for unauthorized or inappropriate actions made by my proxy.

Having read this authorization, I hereby agree to abide by the terms of this agreement and grant proxy access to my personal health information via MyCare to the individual named below.

Proxy Name/Relationship:_____ Proxy Date of Birth:_____

Proxy Address:_____ Proxy Phone Number:___(___)_____

City/State/Zip:_____

Expiration Date 6 months 12 months 18 months 24 months
(Please circle the expiration time frame. Authorization will expire in 24 months if not specified.)

Signature of Patient:_____ **Date**: _____