ACCOUNT #	DOB
UNIT #	AGE
ADMIT DATE	SEX

FREDERICK HEALTH HOSPITAL

400 West 7th Street
Frederick, MD 21701

240-566-3300

Patient Name: _____
DOB: _____
MR#: _____
Or Patient Label

FHH CareTrack Patient Portal
Proxy Access Request and Authorization Form

Patient's Authorization

- By signing this proxy request, I understand that I am authorizing FHH to disclose/release my protected health information (PHI) through the FHH CareTrack Patient Portal (CareTrack) to my Proxy. Health information available through CareTrack may include, but is not limited to: health summary, current problem list, current medications, lab results, radiology reports, and appointment information.
- I understand that the health information available to my Proxy may include health information relating to: (1)Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, (2) testing or treatment for substance use, (3) sexually transmitted diseases, or (4) mental or behavioral health or psychiatric care.
- This proxy request is effective until my CareTrack account is inactivated or proxy access is revoked by me.
- I understand that I have a right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing and mail it to: Health Information Management, FHH, 400 West Seventh Street, Frederick, Maryland 21701. I understand that such a revocation will not have any effect on any information already released 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 was signed.
- I understand that the health information disclosed pursuant to this authorization may be re-disclosed by the recipient (Proxy) and no longer protected by federal or state privacy laws.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. If I refuse to sign this authorization, access to my CareTrack account for my Proxy will not be granted.

Legal Guardian, Power of Attorney or Health Care Agent

- By signing this proxy request, I confirm that all documents provided in support of my right to access the identified patient's protected health information (PHI) are true and correct copies and are the most recent documents related to this matter known to me.
- I understand that I will use my own CareTrack account to access the patient's health information.
- I hereby agree that, when my legal authority to act on behalf of the patient has been inactivated, revoked, terminated, or expired, I will immediately notify FHH in writing of the change in authority and mail it to: Health Information Management, FHH, 400 West Seventh Street, Frederick, Maryland 21701.

Parents or Legal Guardian of a Minor Patient

- By signing below, I verify that I have parental rights or legal guardianship rights to access the minor patient's protected health information (PHI).
- I understand that I will use my own CareTrack account to access the patient's health information.
- I confirm that there are no court orders or restraining orders in effect limiting my access to the minor patient's health records and/or health information.
- I understand that communication on behalf of the minor patient through CareTrack must be sent from the minor patient's record and responses will be received in the minor patient's records. CareTrack e-mail alerts will be sent to the e-mail address entered under Parent/Legal Guardian ("Proxy") information.
- For a child age 0-12 years, I will be granted full access to the child's CareTrack records. On the child's 13th birthday, I will no longer have access to the child's CareTrack records, but may obtain the child's medical records from FHH's Health Information Management.

_____ _____
Patient/Parent/Legal Guardian/Decision Maker Signature (Required) Date and Time

_____
Relationship to Patient (Required)

For Office Use Only: Date Received: _____
Id Verified: __ License __ Other: _____
Documents Verified: __ Court Order __ POA __ Advance Directive
__ Birth Certificate __ Other: _____
Circle one: Approved/Denied by: _____

ACCOUNT #	**DOB**
UNIT #	**AGE**
ADMIT DATE	**SEX**

FREDERICK HEALTH HOSPITAL

400 West 7th Street
Frederick, MD 21701

240-566-3300

Patient Name: _____
DOB: _____
MR#: _____
Or Patient Label

FHH CareTrack Patient Portal
Proxy Access Request and Authorization Form

1. Patient Information: *Required Sections ; please print clearly.
   *Name (Last, First, Middle Initial): _____
   *Street Address: _____
   *City: _____ *State: _____ *Zip: _____
   E-mail Address: _____
   *Date of Birth: _____ *Phone Number: (____)____-_____

2. Proxy Information: All sections required; please print clearly.
   *Name (Last, First, Middle Initial): _____
   *Street Address: _____
   *City: _____ *State: _____ *Zip: _____
   *E-mail Address: _____
   *Date of Birth: _____ *Phone Number: (____)____-_____
   Relationship of Proxy to Patient (select one):
   ___ Guardian ___ Healthcare Agent ___ Power of Attorney
   ___ Spouse/Domestic Partner ___ Child ___ Mother
   ___ Father ___ Sibling ___ Friend
   ___ Other: _____

3. Please check one of the boxes below that best describes the proxy access requested. Please note that for all types of proxy access, the patient's chart will be accessed through the Proxy's CareTrack Patient Portal account.

Adult Patient (Access to an adult Patient's Portal records).
Select one:

__ Adult Patient
- The Patient must attach a copy of the patient's photo ID and sign the Proxy Access Request form.
- Authorization for Proxy Access is valid until revoked in writing by the Patient.

__ Legal Guardian of Adult Patient
- The Guardian must attach a copy of the Court Order of Guardianship of the Person and a copy of the Guardian's photo ID to this form.
- The Guardian signs Proxy Access form.
- The Guardian agrees to notify FHH immediately in case of any change in authority.

__ Power of Attorney or Healthcare Agent
- Individual must attach a copy of the legal paperwork and a copy of his/her photo ID to this
- form.
- Individual signs Proxy Access form. Individual agrees to notify FHH immediately in case of any change in authority.

Minor Patients (Access to a minor Patient's Portal records is limited to individuals with parental rights or permanent guardianship rights).

My relationship to the Minor Patient is (select one):
__ **Parent**: Must attach a copy of his/her photo ID and provide proof of parentage. Parent signs the Proxy Access Request form.
__ **Permanent Legal Guardian**: Must attach a copy of his/her Photo Id and provide a copy of the Court Order of Guardianship of the Person. Guardian signs the Proxy Access Request form.
- You will be granted access to the Minor Patient's Portal records until he/she turns 13 years of age.
- When a Child Patient reaches age 13, access to Portal records by a parent or legal guardian will terminate.
- You may receive a copy of your child's health records until the child reaches the age of 18 from the Health Information Management Department (240-566-3440).

For Office Use Only: Date Received: _____
Id Verified: __ License __ Other: _____
Documents Verified: __ Court Order __ POA __ Advance Directive
__ Birth Certificate __ Other: _____
Circle one: Approved/Denied by: _____