



ETIQUETA

Formulario de acceso para el apoderado

Acceso un registro AveraChart del paciente

Para tener acceso al registro AveraChart de un paciente cuya atención médica ayuda a gestionar el apoderado, complete este formulario. El hecho de completar este formulario establecerá un AveraChart para el apoderado y para el paciente. Tenga en cuenta que el apoderado tendrá acceso a los registros del paciente a través del acceso para apoderados. Se deberá completar un formulario separado para cada paciente y/o apoderado. Espere aproximadamente siete (7) días hábiles para que se establezca el acceso para el apoderado. Después de que se establezca el acceso para el apoderado se enviará un mensaje de correo electrónico a la dirección proporcionada. Haga clic en el enlace del correo electrónico para tener acceso a AveraChart. El enlace caducará a los 10 días.

Información sobre el paciente

Complete esta sección con información sobre el paciente a cuyo AveraChart el apoderado está solicitando acceder.

* Campos obligatorios.

*Nombre (apellido, nombre, segundo nombre): _____ *Fecha de nacimiento: _____ *Sexo: M / F

Últimos 4 dígitos del núm. de seguridad social: _____ *Número de teléfono: _____

Dirección: _____ Ciudad: _____ Estado: _____ Código postal: _____

Información del apoderado

Esta sección la debe completar la persona que solicita el acceso al AveraChart de un paciente.

* Campos obligatorios.

*Nombre (apellido, nombre, segundo nombre): _____ *Número de teléfono: _____

Dirección: _____ Ciudad: _____ Estado: _____ Código postal: _____

*Correo electrónico: _____

Si es paciente de un centro AveraChart y quiere tener acceso a su propio registro, proporcione:

*Fecha de nacimiento: _____ *Sexo: _____

Autoridad del apoderado

_____ El paciente es un menor de edad de menos de 12 años y soy el padre/la madre del paciente. No hay una orden judicial que limite mis derechos a obtener información médica sobre el paciente menor de edad.

_____ El paciente es un menor de edad de menos de 12 años y soy el tutor del paciente. Consulte la documentación adjunta que sigue en vigencia.

_____ El paciente es una persona incapacitada y soy el tutor del paciente. Consulte la documentación adjunta que sigue en vigencia.

_____ El paciente, incluidos los pacientes de 12 años o más, ha autorizado mi acceso a la información del registro médico. Consulte la Sección para el paciente a continuación.

_____ Otro: _____

El acceso para el apoderado en el caso de los menores de edad está limitado al padre, la madre y los tutores legales. Si no se ha autorizado el acceso como apoderado, puede solicitar copias del registro médico comunicándose con Health Information Management (Gestión de información médica) del centro en el que se proporcionó la atención.

Términos y aceptación de AveraChart

- Entiendo que AveraChart tiene como objetivo ser una fuente de información médica confidencial segura en línea. Si comparto mi identificación y contraseña de AveraChart con otra persona, esa persona podrá ver cualquier información médica a la cual yo tenga acceso a través de AveraChart.
- Acepto que es mi responsabilidad seleccionar una contraseña confidencial, mantener mi contraseña de forma segura y cambiar mi contraseña si creo que se ha visto comprometida de cualquier manera.
- Entiendo que AveraChart contiene información médica limitada seleccionada del registro médico de un paciente y que AveraChart no constituye el registro médico completo.
- Entiendo que mis actividades dentro de AveraChart pueden controlarse a través de una auditoría por computadora y que las entradas que realice pueden formar parte del registro médico del paciente.
- Entiendo que el acceso a AveraChart se proporciona para comodidad de los pacientes y que el acceso a AveraChart se puede desactivar en cualquier momento por cualquier motivo. Entiendo que el uso de AveraChart es voluntario y no estoy obligado a usar AveraChart o a autorizar a un apoderado para AveraChart.



LABEL

FOR REFERENCE

Proxy Access Form

Access to a patient's AveraChart Record

To request access to the AveraChart record of a patient whose medical care the proxy helps manage, please complete this form. Completing this form will establish an AveraChart for the proxy and for the patient. Please note, the proxy will access the patient's records through the proxy's access. A separate form will need to be completed for each patient and/or proxy. Please allow approximately seven (7) business days for proxy access to be established. After proxy access is established an e-mail will be sent to the address provided. Click on the link in the e-mail to gain access to AveraChart. The link will expire at 10 days.

Patient Information

Complete this section with information about the patient whose AveraChart the proxy is requesting to access.

* Required Fields.

*Name (last, first, middle name): _____ *Date of Birth: _____ *Gender: M / F
Last 4 digits of SSN: _____ *Phone Number: _____
Street Address: _____ City: _____ State: _____ Zip: _____

Proxy Information

This section should be completed by the individual requesting access to a patient's AveraChart.

* Required Fields.

*Name (last, first, middle name): _____ *Phone Number: _____
Street Address: _____ City: _____ State: _____ Zip: _____
*E-mail: _____

If you are a patient at an AveraChart facility and would also like access to your own record, please provide us with:

*Date of Birth: _____ *Gender: _____

Authority of Proxy

- _____ Patient is a minor under 12 years old and I am the patient's parent. My rights to seek medical information on the minor patient have not been limited by court order.
- _____ Patient is a minor under 12 years old and I am the patient's guardian. See the attached paperwork which is still in effect.
- _____ Patient is an incapacitated person and I am the patient's guardian. See the attached paperwork which is still in effect.
- _____ The patient, including patients at least 12 years old and older, has authorized my access to medical record information. See Patient section below.
- _____ Other: _____

Proxy access for minors is limited to parents and legal guardians.

If proxy access is not authorized, you may request copies of the medical record by contacting Health Information Management at the facility where care was provided.

AveraChart terms and agreement

- I understand that AveraChart is intended as a secure online source of confidential medical information. If I share my AveraChart ID and password with another person, that person may be able to view any health information to which I have access through AveraChart.
- 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 it may have been compromised in any way.
- I understand that AveraChart contains selected, medical information from a patient's medical record and that AveraChart does not reflect the complete medical record.
- I understand that my activities within AveraChart may be tracked by computer audit and that entries I make may become part of the patient's medical record.
- I understand that access to AveraChart is provided as a convenience to its patients and that access to AveraChart may be deactivated at any time for any reason. I understand that use of AveraChart is voluntary and I am not required to use AveraChart or to authorize an AveraChart proxy.



LABEL

FOR REFERENCE

Proxy Access Form

Proxy:

I acknowledge and agree that:

- The patient can revoke the proxy access to his/her AveraChart at any time.
- If the patient is under age 12 years, proxy access will be deactivated on the patient's 12th birthday.
- If the patient is aged 12 – 17 years, proxy access will be deactivated on the patient's 18th birthday.
- I will comply with the terms and conditions on the AveraChart web page and this document.
- When my legal authority to act on behalf of the patient has been inactivated, revoked, terminated or expired, I must immediately notify AveraChart in writing of the revocation, termination or expiration and mail it to your: Health facility, Attn: Health Information Management.

▶ _____ / _____ / _____
Proxy Signature Relationship to Patient Date

Patient:

I acknowledge and agree that:

- I will comply with the terms and conditions on the AveraChart web page and this document.
- I choose to designate the person named above as a proxy to my AveraChart, thereby allowing him/her access to AveraChart protected health information, including but not limited to, behavioral health records, and HIV/AIDS test results. I authorize release of any information contained in my AveraChart medical record held by health facilities utilizing AveraChart (a list of facilities can be found at www.averachart.org) to my designated proxy. I understand that the medical information in AveraChart is obtained from my electronic medical record and may include information from all facilities listed in the health facilities' Notice of Privacy Practices.
- I authorize release of this information only through my AveraChart record. This form does not authorize release of my medical record to my designated proxy other than through AveraChart.
- I understand that once information has been disclosed, it potentially may be re-disclosed by the proxy and the disclosed information may not be covered by federal privacy protections.
- Participation in AveraChart and designating an AveraChart proxy is completely voluntary. I understand that I am not required to designate an AveraChart proxy and I am not required to provide this authorization. I also understand that the healthcare facility does not condition any of my health care treatment, payment or other services on whether I provide this authorization.
- I understand that if I no longer want the proxy to have access to my AveraChart, I may revoke his/her access in writing by sending a request to my Avera facility to the attention of Health Information Management. A Proxy Revocation form may also be found at www.averachart.org.
- I understand that if I revoke this authorization, my designated proxy's access to my AveraChart will be ended. I also understand my revocation will not affect any disclosures that were made prior to processing the revocation request.
- Unless proxy access is deactivated or otherwise revoked by patient or patient's legally authorized representative, access shall be granted to proxy until termination of patient's AveraChart.
- **Please check only one box below.** If not answered, the proxy will not have authorization to download my entire medical record.
 - I authorize my proxy to download my entire medical record.
 - I do not authorize my proxy to download my entire medical record.

▶ _____ / _____ / _____
Patient Signature Relationship to Proxy Date

▶ _____ / _____ / _____
Signature of Legal Representative Relationship to Proxy Date

Patient signature not required when patient is under the age of twelve (12) or proxy has legal authority. Please attach relevant document(s).

Return forms to your:
Health facility
Attn: Health Information Management

HIM use only (staff initials)	
_____	Patient signature verified
_____	Approved by HIM
_____	Proxy access granted
_____	Form scanned into medical record