This form is an authorization that will permit RMC / RFH to release your medical information to certain designated adult individuals. This form must be completed by the adult patient who is authorizing another adult to access medical information in myHealth.

Please PRINT (except signature) and provide complete information in each section.

PATIENT INFORMATION

Patient Full Legal Name	Date of Birth	Gender		
Complete Mailing Address		City	State	Zip Code
Telephone Number				

By signing this form, I am requesting the person(s) named below access to electronically view my RMC / RFH medical record via myHealth.

AUTHORIZED ADULT 1

Full legal name of person	Telephone Number	Relationship to patient		
Complete Mailing Address		City	State	Zip Code
Email address				

AUTHORIZED ADULT 2

Full legal name of person	Telephone Number	Relationship to patient		
Complete Mailing Address		City	State	Zip Code
Email address				

Please provide signatures on reverse side.

myHealth Adult / Adult Portal Access Authorization

- This authorization is voluntary. I understand that I am not required to designate the person(s) above and I am not required to provide this authorization. I understand that RMC/RFH does not condition any of my health care treatment, evaluation, payment, or other services on whether I provide this authorization. I understand, however, that if I do not provide this authorization, RMC/RFH is not permitted to provide access to my myHealth record to the person(s) listed above.

- I understand by signing this application, I am authorizing the person(s) listed above to electronically access and view my medical record via myHealth. This form does not authorize release of my medical records by other methods or in other forms. I understand that all information made available in my myHealth will also be made available to the authorized person(s) and RMC/RFH has no ability to limit the information viewed by the authorized person(s). Further, RMC/RFH has no control over what the authorized person does with the accessed information. I also acknowledge that: 1) the authorized person(s) may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations.

- I understand I may choose to revoke access at any time.

- If I choose to cancel this consent at a later date, I must send written notification to the Health Information Services Department, Regional Medical Center, 709 West Main Street, Manchester, IA 52057.

- If this consent is cancelled, I understand and acknowledge that information previously viewed by the above named person(s) would not be considered a breach of confidentiality.

This agreement and authorization will continue until cancelled by me or my health care power of attorney, if applicable, pursuant to the process described above. I understand that RMC / RFH reserves the right to revoke the access of the authorized person(s) at any time for any reason.

Patient Signature	Date

OR

Power of Attorney or Legal Guardian Signature	Date

*(Copy of completed Durable Power of Attorney for Health Care or Legal Guardian appointment must be on file)

Witness Signature

Return completed document to: Health Information Services Department
Regional Medical Center
709 West Main Street, PO Box 359
Manchester, IA 52057

myHealth Adult / Adult Portal Access Authorization