OCHSNER HEALTH SYSTEM
OCHSNER MY HEALTH PROXY ACCESS REQUEST AND AUTHORIZATION FORM
ADULT

Patient Information

Patient's Name: _____

Patient's Clinic Number: _____

Patient's Street Address:

_____

_____

Patient's Date of Birth: _____

Last Four Digits of Social Security Number:

_____

Proxy Requestor Information

Name of Person Requesting Proxy Access:

_____
Print Name

_____
Signature of Proxy Requestor

Proxy's Date of Birth: _____

Proxy Requestor's E-mail Address:

_____

Proxy Requestor's Telephone Number:

_____

Please check relationship to Patient (Multiple selections accepted):

**** This request MUST be accompanied by a copy of legal paperwork verifying the authority of the patient's personal representative (i.e., court-appointed guardian)**

___ Durable Power of Attorney for Healthcare******

___ Caregiver for competent Senior patient (both patient and person requesting must sign below)

___ Legal Guardian ******

___ Parent
___ Child
___ Sibling
___ Significant Other

___ Spouse
___ Step-Parent
___ Step-Child
___ Other Relationship (Explain):_____

Select the Proxy's Level of Access:

___ Full:
Allows grantee to view your medical information, refill medications, send messages, and schedule appointments on your behalf.

___ Read-Only:
Allows grantee to view your medical information, but cannot communicate on your behalf.

___ Communication-Only:
Allows grantee to send messages and schedule appointments on your behalf, but not to view your medical information.

As the patient/patient's personal representative, I hereby authorize Ochsner Health System to release health information on the above patient via Ochsner My Health according to Ochsner My Health terms and conditions. I understand that this may include the patient's treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnoses. I understand that it is my obligation to notify Ochsner in the event access circumstances change and that I may discontinue proxy access at any time by contacting myochsner@ochsner.org.

_____ _____
Signature of Patient Date

_____ _____
Signature of Prospective Proxy Date

Please submit this form and any required legal documents by:

E-mail: myochsner@ochsner.org **Fax: 504-842-7905**

Mail: Ochsner Health System Operations Center Data Governance 1201 Dickory Ave. Harahan, LA 70123

Please note that submittal of this form without accompanying verifying information will delay the processing of this request. Access requests delayed for this reason will remain open for a period of 60 days following receipt of the initial request before being terminated. Once terminated, this form and the online request must be resubmitted.