PhoebePatient

Adult Proxy Health Care Agent under an Advance Directive for Health Care/ Permanent Legal Guardian Request Form

This form to be completed by a person ("Proxy") who has the correct legal documents to act as DPOA or Permanent Legal Guardian for a patient of Phoebe Putney Health System (PPHS) facility **who is 18 or over** and who represents he/she is entitled to access portions of the patient's electronic protected health information ("ePHI") maintained at PPHS through Phoebe Patient.

Proxy makes sure all fields/signatures are completed and shows photo ID and legal documents in Health Information Management when submitting forms.

Patient Information: **If the patient will be logging into his/her Phoebe Patient account, the patient also needs to create a Phoebe Patient account.**

Patient's Name:		DOB:	
Address:			
Phone Number:		Last 4 SSN:	

Proxy Information: **If the Proxy sees providers at PPHS, the Proxy also needs to create an account in Phoebe Patient.**

Email Address:					
Proxy's Name:		Proxy's DOB:		Phone #:	
Street Address:					
City:		State:		Zip:	

My Relationship to the patient is as follows:

☐ **Permanent Legal Guardian of the Patient** – Proxy must attach a copy of the Court Order Appointing Guardian and Letters of Guardianship verifying the Proxy's status as permanent legal guardian of the patient.

OR

☐ **Advance Directive for Health Care** – Proxy must attach a copy of the valid Advance Directive for Health Care or Durable Power of Attorney for Healthcare.

By signing below, I acknowledge and agree that:

- I will be using my own Phoebe Patient account at PPHS to access the patient's Phoebe Patient account.
- I will comply with the terms and conditions on the Phoebe Patient web page (located at http://www.PhoebePatient.com, select the Phoebe Patient Portal Agreement link on the page) and this document.
- I have the proper documentation authorizing me as a legal representative for this patient, thereby allowing me access to his/her ePHI through Phoebe Patient.
- When my legal authority to act on behalf of the patient has been inactivated, revoked, terminated or expired, I must immediately notify PPHS in writing of the revocation, termination or expiration and mail it to: Phoebe Putney Health System, Health Information Management (HIM), P.O. Box 3770, Albany, GA 31706.
- It is the patient's and/or their agent's responsibility to inform HIM of any changes in the proxy's legal status.
- I have completed the Phoebe Patient Authorization for Use or Disclosure of Electronic Protected Health Information.
- If there are any questions concerning this form, please contact 229-312-5465 for assistance.

X_____/_____/_____/_____

Proxy Signature (Required) | Relationship to Patient (Required) | Date (Required) | Time (Required)

This proxy will expire 3 years from the signed date and will need to renewed to continue reviewing patient information.

"Please return completed forms via email to phoebepatient@phoebehealth.com or fax to 229-312-6005"