St. Luke's MEDICAL GROUP

MyStLukes Patient Portal

PROXY Authorization

Please PRINT demographic information as clearly as possible. The accuracy of this information helps ensure the correct person is provided with authorization to access your St. Luke's Hospital Patient Portal.

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

Date of Birth: ___/___/_____ Phone: (____) ____- _____ Email: _____ @ _____

Address: _____

Gender: M / F Preferred Language: _____ Last 4 Digits of Social Security Number: _____

ACCESS by PROXY INFORMATION

(The person authorized to access the Patient's health care information)

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

Date of Birth: ____/ _____/ _____ Last 4 Digits of Social Security Number: _____

Address: _____

Relationship: _____ Phone: (____) ____- _____ Email: _____ @ _____

Does the Proxy have an active Patient Portal account with St. Luke's Hospital? Y / N
Has the Proxy been a patient at St. Luke's Hospital in the past? Y / N

Adult	**Minor Child**
Access to another adult's health information	Access to a minor child's health information
This section also applies to Emancipated Minors (Copy of proof of Emancipation must be attached to this form) The patient must sign this form to provide authorization for release of their health information. Authorization is valid until revoked in writing by the patient.	My relationship to this patient is; (check one) Parent ☐ Permanent Legal Guardian ☐ (Copy of Court Order Appointing Guardian and Letters of Guardianship verifying Proxy's status must be attached to this form)
Guardian of Adult Check One: Legal Guardian (Court Appointed) ☐ Healthcare Power of Attorney ☐ (Copies of legal documents verifying authority and/or guardianship must be attached to this form)	Parent or guardian of a minor child will have limited access to the child's health information through MyStLukes portal until the child turns 13 years of age. Once a child reaches the age of 13, all MyStLukes proxy accounts are terminated; however, the parent may contact Health Information Services to request copies of the minor's health information.

Signature: _____ Date: ___ / ___ / _____ Time: _____

Relationship to Patient: (Self or other as above) _____

AUTHORIZATION FOR ACCESS

To be completed by the Patient

ADULT PATIENT:

By signing this proxy request, I understand that I am giving my permission for St. Luke's Hospital to disclose my protected health information (PHI), through the MyStLukes patient portal, to my proxy. Information includes, but is not limited to health summaries, current problem list, medications, lab results, provider communications, appointment information, and may include information relating to (1) AIDS or HIV infection; (2) treatment of drug or alcohol use; or (3) mental or behavior health or psychiatric care; or (4) sexually transmitted diseases.

- This proxy request is effective until my MyStLukes portal account is inactivated or I revoke proxy access in writing.
- This proxy request includes information (as above) that was created or existed before the date the form is signed, as well as records that are created after the date the form is signed.
- I understand I have the right to revoke this authorization at any time. If I wish to revoke this authorization, I must do so in writing to St. Luke's Health Information Services Department at 111 S. Woods Mill Road, Chesterfield, MO 63017. I also understand that such a revocation will not have any effect on any information already released to my proxy.
- I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and therefore will no longer protected by federal or state privacy laws.

I understand that *MyStLukes* contains selected, limited medical information from my medical record and that *MyStLukes* does not reflect the complete contents of the medical record. I also understand that a paper copy of my medical record may be requested from the St. Luke's Health Information Services Department or from my physician's office.

To be completed by the Proxy

Reminder: Copies of any legal documents must be attached to this form when submitting for process. Incomplete forms will not be accepted.

PARENT:

I represent and warrant that:

- I have parental rights or legal guardianship rights to access this child's health records.
- I have not been denied periods of physical placement with the child and there are no court or restraining orders in effect, limiting my access to the child's health information.

By signing below, a parent acknowledges and agrees:

- I will be using my own MyStLukes patient portal to access my minor child's MyStLukes portal account.
- Communication on behalf of my child though the MyStLukes portal must be sent from and to my child's account. Parent MyStLukes email alerts will be sent to the email provided on Page 1.
- My access to my child's MyStLukes patient portal account will terminate when my child turns 13 years old.

I understand that *MyStLukes* contains selected, limited medical information from my child's medical record and that *MyStLukes* does not reflect the complete contents of the medical record. I also understand that a paper copy of my child's medical record may by requested from St. Luke's Health Information Services Department or my child's physician's office.

LEGAL GUARDIAN:

My signature below certifies that all documents I have provided in support of my request for access to the patient's protected health information, are true, complete and correct copies, and are the most recent documents related to this matter. When my legal authority to act on behalf of the patient has been inactivated, revoked, terminated or expired, I agree to immediately notify St. Luke's Hospital, in writing, of the change and the effective date, and provide copies of any legal documentation that may be applicable.

Adult Patient – Parent – Legal Guardian	Proxy
By signing below, I acknowledge and agree to comply with the terms and conditions, as above.	**By signing below, I acknowledge, agree and understand;** • I will be using my own *MyStLukes* patient portal account to access the patient's *MyStLukes* patient portal account. • I will comply with the terms and conditions, as above. • The patient may revoke, in writing, access to their *MyStLukes* patient portal account, at any time.

_____ _____

Patient, Parent or Legal Guardian Signature **Proxy Signature**

_____ _____

Printed Name **Printed Name**

Date: ____ / ____ / _____

Mail Completed Form(s) To:
St Luke's Hospital
Health Information Services – Correspondence
111 S. Woods Mill Road
Chesterfield, MO 63017

Fax Completed Form (s) To:
Fax#: 314-205-6106
For Questions About this Form Call:
314-542-4729
8:30 AM – 4:30 PM Monday - Friday