



Patient Name: _____ MRN: _____ Date of Birth: _____ <b>Complete above information or attach patient label to each page.</b>
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## Adult-to-Adult Proxy Authorization Form

### Adult Access to the MyLGHealth Account of an Adult Patient (Adult-to-Adult Proxy) Terms & Conditions

Adults can access the MyLGHealth account of another adult patient with proper authorization from that patient. The information disclosed through MyLGHealth will allow those with proxy access to play a more active role in the healthcare of the patient listed on the Adult-to-Adult Proxy Authorization Form.

Requirements for obtaining proxy access to an adult patient’s MyLGHealth account:

- Adult-to-Adult Proxy Authorization Form must be completed and signed.
- The individual requesting access must have their own MyLGHealth account or one will be established for them.

I understand that the following terms and conditions apply:

- **MyLGHealth is not to be used in an emergency.**
- I must have a MyLGHealth account or an account will be established for me.
- I must log in to MyLGHealth with my own user ID and password.
- I must click on the tab labeled with the name of the patient listed on the Adult-to-Adult Proxy Authorization Form to access their medical information.
- To receive notifications about new information in the account of the patient listed on the Adult-to-Adult Proxy Authorization Form, I must provide a valid email address.
- I understand that my activities with MyLGHealth are tracked by computer audits.
- I agree to abide by the Terms and Conditions of the MyLGHealth site.
- I understand that Penn Medicine Lancaster General Health reserves the right to revoke proxy access to the account of the patient listed on the Adult-to-Adult Authorization Form at any time for any reason.
- If I have a MyLGHealth account, I will receive a message in that account when access to the account of the patient listed on the Adult-to-Adult Proxy Authorization Form is available. This is typically within 5 to 7 business days after the completed authorization form is received.
- If I do not have a MyLGHealth account, I will receive a MyLGHealth activation e-mail with instructions on how to create one. If I do not activate my account within 60 days of receiving my e-mail, the account of the patient listed on the Adult-to-Adult Proxy Authorization Form will be deactivated. Therefore, I should promptly activate my account.
- Communications on behalf of the patient listed on the Adult-to-Adult Proxy Authorization Form must be sent from their account and responses will be received in their account.
- By activating my MyLGHealth account my communication preferences will default to MyLGHealth. Penn Medicine Lancaster General Health may, from time to time, wish to communicate with me through MyLGHealth about health-related benefits and services that may be of interest to me.
- Entries I make to the MyLGHealth account of the patient listed on the Adult-to-Adult Proxy Authorization Form may become part of their legal medical record.
- Mental health information you view through proxy access to MyLGHealth may be protected by State statute. State regulations limit your right to make any further disclosure of such information without prior written consent of the person to whom it pertains.
- HIV/AIDS information you view through proxy access to MyLGHealth is protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.



**Please enter the information of the patient whose MyLGHealth account access is being requested to:**

Patient's Name: \_\_\_\_\_

Medical Record #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Please enter the information of the proxy (Individual requesting access):**

Name: \_\_\_\_\_

Last 4 SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Former Name(s) – e.g., maiden name: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship to patient:  Son  Daughter  Spouse  Power of Attorney  Other

If Other, please specify: \_\_\_\_\_

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**This form must be signed by the patient in the presence of a Penn Medicine Lancaster General Health employee who is not the patient or proxy.**

I hereby authorize (proxy's full name) \_\_\_\_\_ to access my protected health information **including but not limited to records relation to alcohol and drug use, HIV/AIDS and other sexually transmitted diseases, birth control, mental health and genetics** via MyLGHealth for the purpose of him/her having involvement in my healthcare. Further, I authorize the above named individual to have the ability to act on my behalf via MyLGHealth. I may revoke this proxy access any time I wish, by means of my personal MyLGHealth account or in writing. I understand that I am authorizing Penn Medicine Lancaster General Health to release all information contained in my MyLGHealth Account as described above. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by relevant federal and/or state law.

I understand that it is my choice to give my authorization and that my choice will not affect my care and treatment at Penn Medicine Lancaster General Health.

\_\_\_\_\_  
Patient Signature (granting access) Date \_\_\_\_\_ Time \_\_\_\_\_

\_\_\_\_\_  
Patient Printed Name

I have read and understand the Adult Access to the MyLGHealth Account of an Adult Patient Terms & Conditions as provided on the previous page and agree to act as a proxy for the above named patient.

\_\_\_\_\_  
Proxy Signature (requesting access) Date \_\_\_\_\_ Time \_\_\_\_\_

\_\_\_\_\_  
Proxy Printed Name

\_\_\_\_\_  
Penn Medicine Lancaster General Health Employee Signature Date \_\_\_\_\_ Time \_\_\_\_\_

\_\_\_\_\_  
Penn Medicine Lancaster General Health Employee Printed Name

**Completed forms may be sent by the following methods:**

1. **Scan and e-mail to:** LGLegalForms@lghealth.org
2. **Fax to:** 717-544-8884
3. **Mail to:** Health Information Management  
Attention: Document Imaging  
555 North Duke Street  
PO Box 3555  
Lancaster PA 17604-3555