PROXY DESIGNATION AND AUTHORIZATION FOR MYASPIRUS

I, _____, hereby designate_____ as my PROXY and authorize
(Patient Name) (Proxy Name)
the following access to my MyAspirus account: (*Choose only one)*

☐ **FULL ACCESS** ☐ **READ ONLY ACCESS**

Please complete this document and submit it via one of the methods below:
Email: Aspirushealthinformation@aspirus.org **Fax:** 715-847-2187
Mail: Aspirus Health Information Management 333 Pine Ridge Blvd., Wausau, Wisconsin 54401

TERMS AND CONDITIONS

These terms and conditions apply to FULL ACCESS:
I understand that by allowing FULL ACCESS, I authorize my PROXY to:

1) See and access the same medical information that I am able to on MyAspirus; and
2) Perform all of the functions MyAspirus allows me to perform including, but not limited to, the ability to schedule and cancel appointments, communicate with Providers, provide responses to questionnaires, and request medication refills.

I further understand that Aspirus does not restrict my PROXY's FULL ACCESS to MyAspirus in any manner.

These terms and conditions apply to READ ONLY ACCESS:
I understand that by allowing READ ONLY ACCESS, I authorize my PROXY to: see and view the information available on the MyAspirus account.
I understand that with READ ONLY ACCESS, my PROXY will not be able to utilize or operate any of the functionality available on MyAspirus. My PROXY will not be able to schedule or cancel appointments, communicate with Providers, respond to questionnaires or request medication refills. I understand that other than as stated above, Aspirus does not restrict my information viewable to the PROXY via READ ONLY ACCESS.

These terms and conditions apply to both FULL ACCESS and READ ONLY ACCESS:

- **WRITTEN REQUEST FOR REVOCATION**: I understand that I may revoke this authorization and PROXY designation at any time but must do so by delivering a written request for revocation to Aspirus Health Information's contact options above. I understand that it may take up to ten (10) business days for the revocation to be processed. I agree to hold Aspirus, Inc. and its subsidiaries and affiliates harmless against any disclosures of medical information made prior to a processed revocation.
- I understand that information disclosed to my PROXY pursuant to this authorization may be subject to redisclosure by my PROXY and no longer protected by HIPAA and related state and federal law.
- I understand that my treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I allow PROXY access pursuant to this authorization.

BOX A — REQUIRED INFORMATION/SIGNATURES

The information in Box A must be provided in full for all PROXY ACCESS requests.

PATIENT	**PROXY**
Name:_____	Name: _____
Date of Birth:_____	Date of Birth:_____
Address:_____	Address:_____
_____	_____
Email: _____	Email: _____
Signature:_____	Signature:_____
Date:_____	Date:_____

(If the patient is an adult, only Box A needs to be completed. If the patient is a minor, see Box B & C below. If the patient is incapacitated or incompetent, see Box C below.)

You are entitled to a copy of this authorization after you sign and complete it.

BOX B	SIGNATURES FOR MINOR PATIENT WI & MI UNDER 18, MN UNDER 12

If the patient is a minor, complete this section.

- To authorize READ ONLY ACCESS or FULL ACCESS to a Parent or Person with legal custody, only one (1) Parent or Person with legal custody needs to sign.
- To authorize READ ONLY ACCESS to any third party, only one (1) Parent or Person with legal custody of the minor needs to sign.
- To authorize FULL ACCESS to any third party, all Parents or Persons with legal custody of the minor must sign.
- When minor turns 18(Additionally when a MN minor turns 12; See box C), PROXY ACCESS (whether READ ONLY or FULL ACCESS) shall automatically terminate.
- State law allows certain minors to block access to certain medical information despite this PROXY ACCESS.

PARENT/LEGAL CUSTODIAN

Name:_____
Address:_____
Signature:_____
Date:_____
Relationship to Minor Patient:_____

PARENT/LEGAL CUSTODIAN

Name:_____
Address:_____
Signature:_____
Date:_____
Relationship to Minor Patient:_____

BOX C	SIGNATURES FOR MN MINOR, 12 AND OLDER

I authorize the above individual to participate in Aspirus St. Luke's myCare Patient Portal as my proxy. I understand that my proxy will have the same access and privileges that I have for the Patient Portal. I understand that this allows my proxy online access to my personal health information. My proxy will be able to view portions of my record that I am able to view. I also understand that additional information may be made available to my proxy through the patient portal as Aspirus St. Luke's continues to implement this product. This authorization is valid until the age of 18 unless revoked by me sooner. I understand that a written request is necessary to revoke or cancel this authorization. However, I understand that my revocation will not be effective as to uses and/or disclosures already made in reliance upon this authorization. I realize that the information used and/or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy laws.

Patient Acknowledgment

_____
Signature of Patient (Required for patients 12 and older*), Date

Proxy Acknowledgment

_____
Signature of Proxy, Date

* For patients 12 years of age and up, access can only be granted with written consent from the patient by them filling out this form (this includes parental access to their minor child's portal information, per Minnesota Statute 144.343, which allows minors to independently consent to evaluation and treatment of certain conditions. The proxy authorization expires when the patient turns 18 years old). Legal decision maker authorization is also required, in addition to the minor patient (age 12-17), when proxy access is granted to someone other than the legal decision maker

BOX D	SIGNATURE FOR INCOMPETENT/INCAPACITATED PATIENT

If the patient is incapacitated or incompetent and not capable of signing, the patient's Agent or Guardian <u>must also</u> complete this section.

Signer's relationship to patient (Health Care Agent or Legal Guardian) (circle one)

Signature of Guardian or Agent: _____ **Date**:_____

(Note: Agent or Guardian may grant either type of ACCESS to self. Provide all patient and PROXY information above. Aspirus may require proof of your status as Health Care Agent or Legal Guardian.)

You are entitled to a copy of this authorization after you sign and complete it.