Incapacitated Patient
Request for Proxy Access

Please allow 10 business days for processing

Send completed form to one of the following or hand in at patient's clinic

Fax: 866-846-7864

Postal: UnityPoint Health
Attn: MyUnityPoint Registration
3851 River Ridge Drive NE
Cedar Rapids IA 52402

Contact Technical Support: 877-224-4430

Patient's Name: _____ Patient's Date of Birth: _____
First MI Last

Patient's Current Home Mailing Address:

_____
Street Address City State Zip Code

Patient's Clinic: _____ Patient's Primary Care Provider: _____

Patient's E-mail address: _____

Patient's Social Security Number: _____

Proxy Name: _____ Proxy Date of Birth: _____
First MI Last

Proxy Current Home Mailing Address:

_____
Street Address City State Zip Code

Proxy E-mail address: _____ Proxy Phone: _____

Proxy Social Security Number: _____

If you would like the Proxy added for a specific time frame, please fill in the expiration date below. Note: If you do not specify a different time frame for expiration, this consent will be valid from the date of your signature below and expire in 5 years.

Proxy End Date: _____

Identify your relationship to the Proxy: ☐ Spouse ☐ Mother ☐ Father ☐ Child ☐ Other _____

(Please initial each box) I understand that my authorized proxy will have access to the following information:

☐ **Mental health information**

☐ **HIV/AIDS status**

☐ **Genetic testing**

☐ **Substance abuse treatment**

NOTE: you must authorize access to all of the above types of sensitive health information in order to grant proxy access to the person designated above. I understand that I have a right to refuse to complete this authorization and that the consequences of refusing to complete the authorization are that I will not be able to grant proxy access to my MyUnityPoint patient portal records for the proxy person I have designated on this form. I further understand that if I choose not complete this authorization, it will not impact my ability to obtain treatment, payment enrollment or eligibility for benefits.

I understand the individual named as my proxy on the form above will be able to view my health information in the same manner that I do in the MyUnityPoint patient portal. **I understand that this authorization applies to my health information (including sensitive health information such as mental health information, HIV/AIDS status, genetic testing information and substance abuse treatment) that currently exists at the time I sign this form, as well as to health information related to my future medical appointments and treatments that is created between the time I sign this form and the expiration date listed above.**

I understand that health information disclosed under this authorization to my proxy via the MyUnityPoint patient portal may be subject to re-disclosure by the recipient and no longer protected by state or federal law.

I understand that I have a right to revoke this authorization and terminate the proxy connection for the individual listed as the proxy above at any time except to the extent that UnityPoint Health has already taken action in reliance on my authorization. I understand that I can revoke my authorization and terminate the proxy connection for the individual listed as the proxy above by contacting the UnityPoint Health MyUnityPoint support in writing at 3851 River Ridge Drive NE, Cedar Rapids, IA 52402.

I understand that I have a right to request a copy of this authorization and that I can obtain a copy of this authorization by contacting MyUnityPoint support via phone at (877) 224-4430.

My signature below represents that I authorize UnityPoint Health to allow the person named above as my proxy to have access to my patient health information on the MyUnityPoint patient website. **I understand that UnityPoint Health includes all UnityPoint Health hospitals, clinics and home care services offered by UnityPoint Health.** I understand that this authorizes access to health information related to my health care, including (but not limited to) treatment, evaluations, consultations, lab tests, or procedures performed by UnityPoint Health providers or other affiliated providers including (if applicable) **sensitive health information such as mental health information, HIV/AIDS status, genetic testing information and substance abuse treatment.** The purpose of this access is at my request and is intended to allow the person named as my proxy above to assist me with management of my health care, which may include (but is not limited to) helping me track appointment times and assisting me with managing my health information.

If I am submitting this form with an electronic signature, I understand that submission of my electronic signature via Adobe EchoSign® is a valid signature that meets the requirements for a signature under federal and state law.

Printed Name of Patient _____ Date _____

Signature of Patient or Authorized Representative if Patient is incapacitated _____

***If signed on behalf of the patient, you must provide a copy of the POA for Healthcare document, and the attending physician must sign below.**

As the attending physician to the patient named above, by signing below I attest that, in my medical judgment, the patient is unable to make healthcare decisions at the time of the signing of this Proxy Access Request.

Printed Name of Physician _____ Date _____

Signature of Physician _____