Adult Proxy Access
Requirements and Procedures for accessing the Follow My Health Portal of Adults > 18 years of age

Requirements for accessing an adult's record:

- The individual requesting access must have Medical POA, Legal Guardianship, or the patient must give authority to access their account(legal documentation may be required).
- The Adult FMH Proxy Application, included below, must be completed, signed and submitted for approval.
- Each individual requesting access must establish their own Follow My Health account in order to access the patient's record.
- Acknowledge Follow My Health communication methods are not to be used in an urgent or emergent situation, please call your doctors office or 911 for assistance.

Procedures for proxies accessing a patient's record:

- Typically within 3-5 business days after the completed authorization form is received and approved, a Proxy invite will be emailed to the individual. Invitations will allow the proxy to login to their existing account and select the patient or require the proxy to create an account in their name.
- Once a proxy has established their own Follow My Health account they can access the patient's record by:
    - Logging in to Follow My Health with their own Follow My Health ID and password.
    - Selecting the patient's name from the Hello dropdown to access the patient's medical information.

Proxy access to a patient's record shall be revoked when:

- The patient submits a request to revoke the access online.
- The proxy submits a request to revoke the access online.
- Access disputes cannot be resolved.

Communication on behalf of the patient must be sent under the patient's name. Responses will be received in the patient's name/chart.

The Shenandoah Medical Center reserves the right to revoke access to Follow My Health at any time for any reason.

Adult FMH Proxy Application

Access to the Follow My Health of a Adult Patient

Please print Patient's information.

_____ _____ Male _____ Female _____

Patient's Full Legal Name | Date of Birth | Gender

_____ _____ _____ _____

Complete Mailing Address | City | State | Zip Code

Please print **Proxy/Legal Guardian** Information:

_____ _____ _____

Proxy Full Legal Name | Date of Birth | Telephone Number

_____ _____ _____ _____

Complete Mailing Address | City | State | Zip Code

_____

E-Mail Address

Relationship to Patient: Legal Guardian* ____ Other, please specify*_____

(*Legal documentation is required)

I have read and understand the requirements and procedures for accessing the patient's medical record information online. I certify that I am the legal right to access the patient listed above and that all information provided is correct. I hereby request access to the patient's electronic medical record. I verify the above e-mail address is correct and approve receiving this confidential information (access code) via this e-mail address.

_____ _____

Proxy Guardian Signature | Date

I authorize above individual proxy access to my online Follow My Health Account:

_____ _____

Patient Signature (If Applicable) | Date

Return the Completed Form to:

Shenandoah Medical Center with proof of identity and legal documents as noted above.
Questions may be directed to: 712-246-7402