## Access to Another Adult's MyBSWHealth Record

*To request proxy access to the MyBSWHealth record of an adult patient, please complete this form. The patient or their legal representative must sign this form and provide authorization for release of medical information in MyBSWHealth on the "Authorization for Release of Medical Information to Adult Proxy." Please note that the patient's chart will be accessed through your (the proxy's) MyBSWHealth record. Completing this form will establish a MyBSWHealth record for you and for the patient. Please provide a government-issued ID for identity verification when submitting this form.*

Return forms to Baylor Scott & White Health, Health Information Management Department, 2401 S. 31st Street, Temple, TX 76508 or fax to 254-724-0119. For HealthTexas Provider Network (HTPN) patients, return forms to the Health Information Management department, 8150 N. Central Expressway, Suite 400, Box 47, Dallas, TX 75206 or fax to 214-818-9781.

If you would like to establish proxy access digitally rather than using this form, you may do so in the MyBSWHealth app. Please visit https://my.bswhealth.com/faq for more information.

**Parent/Guardian Information** (All sections required – please print clearly.)

**This section should be completed by the individual requesting access to another adult's MyBSWHealth record.**

Name (*last, first, middle initial*): _____ Date of Birth: _____

Sex: M /F Street Address: _____ City: _____ County: _____ State:___ Zip: _____

Country: _____ Last 4 of SSN: Phone Number (*home/mobile/work – please circle one*): _____

Email Address: _____ BSWH Patient *(please circle one)*: Y / N

**Patient's Information** (All sections required – please print clearly.)

**Complete this section with information about the patient whose MyBSWHealth record you are requesting to access.**

Name (*last, first, middle initial*): _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ Email: _____

### MyBSWHealth Terms and Agreement

- I understand that MyBSWHealth is intended as a secure online source of confidential medical information. If I share my MyBSWHealth ID and password with another person, that person may be able to view my or my child's health information, and health information about someone for whom I have MyBSWHealth proxy.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.
- I understand that access to MyBSWHealth is provided by BSWH as a convenience to its patients and that BSWH has the right to deactivate access to MyBSWHealth at any time for any reason. I understand that use of MyBSWHealth is voluntary and I am not required to use MyBSWHealth or to authorize a MyBSWHealth proxy.
- If the proxy's legal relationship with the patient changes or the patient's proxy agreement is terminated, the patient must inform BSWH immediately by sending written notice to BSWH, Health Information Management Department, Mail Stop 01047, 2401 S. 31st Street, Temple, TX 76508 or fax to 254-724-0119, or for HealthTexas Provider Network (HTPN) patients, to the Health Information Management department, 8150 N. Central Expressway, Suite 400, Box 47, Dallas, TX 75206 or fax to 214-818-9781.
- By signing below, I acknowledge that I have read and understand this MyBSWHealth Adult Proxy Form and the Baylor Scott & White Health MyBSWHealth Terms and Conditions, and attest that I am the authorized proxy of the patient.

**Your (Proxy) Signature** **Date**

**Printed Name** **Relationship to Patient**

I acknowledge that I have read and understand this MyBSWHealth Adult Proxy form. I agree to its terms and choose to designate the person named above as my MyBSWHealth Proxy, thereby allowing them access to my MyBSWHealth medical record.

**Signature of Patient (or authorized person)** **Date**

**Printed Name** **Relationship to Patient**

# Authorization for Release of Medical Information to Adult Proxy

**This form is an authorization that will permit Baylor Scott & White Health to release your medical information to your designated adult proxy. Please read it carefully.**

**This form should be completed by the patient who is authorizing another adult to access the patient's MyBSWHealth record. It must accompany the Adult Proxy Form, which provides the name and information of the individual who the patient is authorizing to access their MyBSWHealth record as a proxy.**

Patient Name (*last, first, middle initial*) _____ Date of Birth: _____

I am requesting _____ *(insert full name of proxy)* to receive access to my health information that is available in my Baylor Scott & White Health (BSWH) MyBSWHealth Record. This person is my designated MyBSWHealth proxy. I authorize BSW H to release the information contained in my MyBSWHealth record to my MyBSWHealth proxy via MyBSWHealth. I understand that the medical information in MyBSWHealth is obtained from my electronic medical record and may include information from all BSWH facilities. I authorize release of this information only through my MyBSWHealth record. This form does not authorize release of my medical record to my designated proxy by other methods or in other forms.

I understand that once information has been disclosed, it potentially may be re-disclosed by the proxy and the disclosed information may not be covered by federal privacy protections.

Participation in MyBSWHealth and designating a MyBSWHealth proxy is completely voluntary. I understand that I am not required to designate a MyBSWHealth proxy and I am not required to provide this authorization. I also understand that BSWH does not condition any of my health care treatment, payment or other services on whether I provide this authorization. However, I also understand that if I do not provide authorization, BSWH is not permitted to provide access to my MyBSWHealth record to my designated proxy.

This authorization will expire upon receipt of my written notice of proxy revocation to BSWH Health Information Management Department, Mail Stop 01047, 2401 S. 31st Street, Temple, TX 76508 or fax to 254-724-0119; or for HealthTexas Provider Network (HTPN) patients, Health Information Management department, 8150 N. Central Expressway, Suite 400, Box 47, Dallas, TX 75206 or fax to 214-818-9781. I understand that if I revoke this authorization, my designated proxy access to MyBSWHealth record will be ended. I also understand my revocation will not affect any disclosures that were made prior to processing the revocation request.

**Signature of Patient (or authorized person)** **Date**

**Printed Name** **Relationship to Patient**

**If person other than the patient signs, indicate authority to sign for patient (e.g., guardian) and attach verification documentation:**

For Official BSWH Use:

**Signature Verification**

____ Verified by ID (Driver's License, State ID, Military ID) _____Form signed in person _____ Signature on File

Send to Health Information Management Department for final verification and granting of proxy access.