MyGENESIS

ACCESS REQUEST FOR ADULT PROXY

PATIENT'S INFORMATION

Patient's Name: _____ Patient's Date of Birth: _____

Address:_____City:_____ State: _____ Zip: _____

Telephone:_____

Existing My Genesis account? ☐ Yes ☐ No

PROXY'S INFORMATION

Proxy's Name: _____ Proxy's Date of Birth: _____

Address:_____City:_____ State: _____ Zip: _____

Email: _____

Telephone:_____

Existing My Genesis account? ☐ Yes ☐ No

My signature represents that I am giving access to my health record to the proxy listed above.
This authorization is voluntary. This agreement will continue until cancelled. Access can be cancelled on-line at www.genesishealth.com/MyGenesis by completing the "**Revoke Access to My Genesis**" form.

Printed Name of Patient: _____

Signature of Patient: _____ Date: _____

Mail Completed Form to:

Genesis Health System
Health Information Management
My Genesis Proxy Access
1227 East Rusholme Street
Davenport, IA 52803

OFFICE USE ONLY
Verified and access entered by: _____ Date: _____

MyGENESIS

REQUEST FOR PROXY ACCESS FOR CHILDREN UNDER 12

PATIENT'S INFORMATION

Patient's Name: _____ Patient's Date of Birth: _____

Address:_____City:_____ State: _____ Zip: _____

Existing My Genesis account? ☐ Yes ☐ No

PROXY'S INFORMATION

Proxy's Name: _____ Proxy's Date of Birth: _____

Address:_____City:_____ State: _____ Zip: _____

Email: _____ Existing My Genesis account? ☐ Yes ☐ No

Telephone:_____

Relationship to Patient: ☐ Father ☐ Mother ☐ *Legal Guardian ☐ *Other
(*Legal documentation is required)

My signature represents that I have the legal right to, and am asking for access to, this patient's health information on My Genesis. I understand when I first access the patient website; I will need to agree to the My Genesis terms and conditions. Once approved, the patient informational records for hospital or clinic visits and treatments that currently exist will be linked to the My Genesis patient website.

This agreement will continue until cancelled by the patient/guardian or automatically once the child reaches age 12. Access can be cancelled on-line at www.genesishealth.com/MyGenesis by completing the "Revoke Access to My Genesis" form.

Printed Name of Proxy: _____ Relationship to Patient: _____

Signature of Proxy: _____ Date: _____

Mail Completed Form to:

Genesis Health System
Health Information Management
My Genesis Proxy Access
1227 East Rusholme Street
Davenport, IA 52803

OFFICE USE ONLY
Verified and access entered by: _____ Date: _____

MyGENESIS

ACCESS REQUEST FOR INCAPACITATED PATIENT

PATIENT'S INFORMATION

Patient's Name: _____ Patient's Date of Birth: _____

Address:_____City:_____ State: _____ Zip: _____

Existing My Genesis account? ☐ Yes ☐ No

PROXY'S INFORMATION

Proxy's Name: _____ Proxy's Date of Birth: _____

Address:_____City:_____ State: _____ Zip: _____

Email: _____

Telephone:_____

Existing My Genesis account? ☐ Yes ☐ No

Relationship to Patient: ☐ Father ☐ Mother ☐ *Legal Guardian ☐ *Other

Legal documentation is required for Incapacitated Patient.

My signature represents that I have the legal right to, and am asking for access to, this patient's health information on My Genesis patient website. I understand when I first access the patient website; I will need to agree to the My Genesis terms and conditions. You will need to provide Durable Power of Attorney or other legal documentation as proof of your right to access this information. **You have the right to revoke this authorization at www.genesishealth.com/MyGenesis by completing the "Revoke Access to My Genesis" form.**

Printed Name of Proxy: _____

Signature of Proxy: _____ Date: _____

Mail Completed Form to:

Genesis Health System
Health Information Management
My Genesis Proxy Access
1227 East Rusholme Street
Davenport, IA 52803

OFFICE USE ONLY

Verified and access entered by: _____ Date: _____

WRITTEN NOTICE OF REVOCATION OF AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

INDIVIDUAL'S INFORMATION

Individuals's Name: _____ Date of Birth: _____

Address:_____City:_____ State: _____ Zip: _____

Telephone: _____

I hereby revoke the authorization generated by me on _____ [insert date], a copy of which is attached to this form.

I understand that this revocation will not be valid where Genesis Health System Affiliated Entities have already acted in reliance upon my authorization.

Signature of Patient (or Personal Representative): _____

Date:_____

Printed Name of Personal Representative: _____

Relationship to Patient: _____

Mail, fax or bring this Written Notice of Revocation to the Genesis Health System Corporate Privacy Office. If you have any questions regarding this form, you may contact the Corporate Privacy Office in person, by telephone at (563) 421-7262.

MAIL TO:
Genesis Health System
Health Information Management
My Genesis Revoke Access Request
1227 East Rusholme Street
Davenport, IA 52803

FAX TO:
(563) 421-7299

OFFICE USE ONLY
The date on which this Written Notice of Revocation was received by Genesis Health System Corporate Privacy Office is:_____. A copy of this Written Notice of Revocation shall be placed in the patient's medical record.