Medical Record #_______________________
ROI # ________________________________

Proxy Photo ID Verified:____________________
MDPOA/Legal Guardianship Verified: ___________

Patient Information

Full Name ______________________________________ Date of Birth ____________________

Email Address ______________________________ Social Security Number: XXX-XX-________ (last 4 digits)

Address ____

City State Zip

Day Phone #_______________ Cell # _________________

Proxy Information

Full Name ______________________________________ Date of Birth ____________________

Email Address ______________________________ Social Security Number: XXX-XX-________ (last 4 digits)

Relationship to Patient ____________________ I have my own personal MyBCH Health Services account: ☐ Yes ☐ No

Address ____

Day Phone #_______________ Cell # _________________ City State Zip

Acknowledgement

- I understand that legal documentation (e.g. Medical Power of Attorney, Guardianship, Legal Personal Representative) **will** be required.
- I understand by submitting this form I, as the Court Appointed Guardian or Medical Power of Attorney (POA), requested proxy access to the above named patient's information that resides in the electronic health record portal (MyBCH Health Services).
- I understand that the patient's medical information is confidential. It is securely maintained in an electronic system by Boulder Community Health.
- I understand that failure to comply with the MyBCH Health Services Patient Portal User Agreement may result in the termination of portal access privileges.
- I understand that the patient's MyBCH Health Services **may** include a diagnosis or reference to the following condition(s): *behavioral health services/psychiatric care; sickle cell anemia; genetic testing; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); or drug and/or alcohol abuse.*
- I understand that information accessed may be subject to redisclosure by the Proxy and is no longer protected by the HIPAA Privacy rule.
- I acknowledge that if I cease to be responsible for the health care decisions of the Patient, I will notify Boulder Community Health immediately.
- I understand that Boulder Community Health reserves the right to revoke access to the MyBCH Health Services Patient Portal at any time for any reason.
- I acknowledge that I have read and understand this Adult Proxy Access - Diminished Capacity/Court Appointed Guardian form and that the full MyBCH Health Services Patient Portal User Agreement are available to me online.
- I understand that this authorization for my access to the patient's MyBCH Health Services Patient Portal account will automatically expire if the Medical Records Department receives notice and documentation that I am no longer the patient's court-appointed guardian of the person, if Boulder Community Health receives notice and documentation that there is a court order or restraining order in effect that would limit my access to the patient's medical records and/or information, when the patient's MyBCH Health Services Patient Portal account is deactivated, or when I revoke this authorization, whichever occurs first.

A signature is required to validate this request. By signing this form, the signer is requesting that the person(s) named above be granted access to electronically view the patient's medical record via the MyBCH Health Services

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Signature and PRINTED Name of Court Appointed Guardian/Medical POA/Proxy **Date**

Submit Completed Form To

For questions or to present forms with identification in person:

Boulder Community Health Medical Records Department
4990 Pearl East Circle, Suite 100, Boulder. 303-415-7760.

Request for Adult Proxy Access - Diminished Capacity/Court Appointed Guardian

PATIENT INFORMATION

Place label here.