El Camino Health

2500 Grant Road, Mountain View, CA 94040-4378
815 Pollard Road, Los Gatos, CA 95032

EL CAMINO HOSPITAL

Telephone: (650)988-7462 | Fax: (650)988-8246

Patient Label

MyCare: Adult Proxy

Authorization to Release Protected Health Information

This form is an authorization that will permit El Camino Health to release your protected health information to your designated adult proxy via MyCare. This form, as well as the MyCare Proxy request form, will need to be completed prior to proxy access.

Patient's Name:_____

Date of Birth: _____/____/_____ Telephone: _____

I authorize **El Camino Health (ECH)** to release the protected health information that is contained in my MyCare record to my designated proxy:

Name of Proxy: _____

This form **does not** authorize release of my protected health information to my designated proxy by other methods.

Expiration: This authorization will expire automatically 10 years from the date of my signature unless otherwise specified: _____

Notice of Patient Rights:

- I understand that once information has been disclosed, it potentially may be re-disclosed by my Proxy and the disclosed information may no longer be protected.
- Participation in MyCare and designating a proxy is completely voluntary.
- Treatment, payment, enrollment, or eligibility for benefits will not be conditional upon participation in MyCare.
- This authorization will expire automatically 10 years from the date of my signature or unless otherwise specified.
- This authorization may be revoked in writing at any time, except to the extent that the information has already been accessed. I must submit my revocation to ECH.
- I have a right to receive a copy of this authorization.

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Mail completed form to:

El Camino Health
Attention: HIM Dept. (Medical Records)
2500 Grant Road
Mountain View, CA 94040

- OR -

Fax to: 650-988-8246

Authorization:

By signing below, I acknowledge that I have read and understand the requirements for designating the person named above as my MyCare Proxy, thereby allowing them access to my MyCare medical record.

_____ _____
Patient/Legal Representative Date

_____
Relationship to Patient

OFFICE USE ONLY:		
Patient relationship verified by:_____	Proxy access approved: ☐Yes ☐No	Activation Letter Sent : ☐Yes ☐No Date Sent:_____