MyCMH Care Portal Proxy Access Procedures

Granting Access:

Caregivers requesting proxy access to a patient's medical record can be granted such access to the MyCMH Care Portal if the patient authorizes their access and each proxy has their own MyCMH Care Portal username and password.

As a proxy, I understand the following requirements:

- I must complete and sign either the **the MyCMH Care Portal Proxy Authorization Form – Adult / Emancipated Minor** or the **MyCMH Care Portal Authorization Form – Minor**, as appropriate. The form must also be completed and signed by the patient or their legal representative (Guardian / Power of Attorney).
    - ***Emancipated minors must provide proof of emancipation.***
    - Access to a non-emancipated minor's online record is only available to birth/adoptive parents or individuals with legal guardianship.
- If I do not have my own MyCMH Care Portal account, I will need to contact the Patient Portal Liaison at (410) 535-8396.
- I agree to abide by the terms and conditions on the MyCMH Care Portal site.
- **MyCMH Care Portal is NOT to be used in an emergency. 'Contact Us' message responses may take up to 3 business days.**

Please return completed *MyCMH Care Portal Proxy Authorization Form* and any supporting documentation to the Calvert Memorial Hospital Health Information Management Department or mail to:

Calvert Memorial Hospital
100 Hospital Road
Prince Frederick, MD 20678
ATTN: Health Information Management (MyCMH Care Portal)

Revoking Access:

Proxy access to a patient's record is revoked when:

- The patient or physician submits a request to revoke access online;
- When a non-emancipated minor reaches age 18;
- Or when a parent/legal guardian requests that access be revoked.

Calvert Memorial Hospital reserves the right to revoke online access to medical information at any time, including in the event that access disputes between parents / guardians / minor cannot be resolved.

Access Guidelines:

- If you have a MyCMH Care Portal account, you will receive a MyCMH Care Portal e-mail message when access to the patient's record is available - typically 5 to 7 business days after completed authorization form is received.

- If you do not have a MyCMH Care Portal account, you may enroll in MyCMH Care Portal by clicking on **Set Up an Account**.

- Communications (e-mails) on behalf of the individual you are caring for must be sent from inside the Patient's MyCMH Care Portal account. Due to software limitations, notification that a response is available can only be sent to the email address entered in the MyCMH Care Portal profile for the patient or the patient's proxy.

- When signed into another person's online medical record, the top of each screen on MyCMH Care Portal will note the name of the person's file being viewed.

MyCMH Care Portal Proxy Authorization Form – Adult / Emancipated Minor

Please enter **Patient's** information

Full Name: _____ Medical Record #: M _____

Address: _____ Social Security #: _____-_____-_____

_____ Date of Birth: _____/_____/_____

E-mail Address: _____ Gender: □ *Male* □ *Female*

I understand that my proxy will have the same access and privileges that I have for the MyCMH Care Portal. I understand that this allows my proxy online access to my personal health information. My proxy will be able to view all portions of my record that I am able to view. I also understand that additional information may be made available to my proxy through the patient portal as Calvert Memorial Hospital continues to enhance this product.

By signing this authorization, I am requesting that Calvert Memorial Hospital give access to my proxy to access my health record on the MyCMH Care Portal. I understand that Calvert Memorial Hospital will require my proxy to sign an acknowledgment and agree to Calvert Memorial Hospital's policies and procedures related to patient portal use.

This authorization is valid until revoked by me. I understand that a written request is necessary to revoke or cancel this authorization. However, I understand that my revocation will not be effective as to uses and/or disclosures already made in reliance upon this authorization. I realize that the information used and/or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy laws.

I agree to allow the individual named below, MyCMH Care Portal access to my medical information currently available and that may become available as a result of future medical care. I understand I may revoke this access at any time. If the patient is unable to sign, please attach Power of Attorney or Legal Guardianship documentation and complete the Proxy section of the form below.

_____ _____

Date Patient Signature

_____ _____

Date Witness Signature

Please enter **Proxy** information

Full Name: _____ Medical Record #: M_____

Address: _____ Social Security #: _____-_____-_____

_____ Date of Birth: _____/_____/_____

E-mail Address: _____ Gender: □ *Male* □ *Female*

Relationship to patient: □ *Son* □ *Daughter* □ *Spouse* □ *Other* (specify): _____

Do you (proxy) have an active MyCMH Care Portal account?

□ Yes – *please read and sign below*

□ No / Don't Know – *You must request your own MyCMH Care Portal user name and password before requesting proxy access. Please contact the Patient Portal Liaison at (410) 535-8396.*

I have read and understand the requirements and procedures regarding accessing a patient's medical record information online as provided on the document titled *MyCMH Care Portal Proxy Access Procedures*. I certify that all information I have provided is correct. I hereby request access to this patient's online medical record.

_____ _____

Date Proxy Signature

_____ _____

Date Witness Signature

MyCMH Care Proxy Authorization Form – Minor

● Please enter **Minor's** information:

Full Name: _____

Address: _____

_____

Date of Birth: _____/_____/_____

Medical Record #: M _____

Social Security #: _____-_____-_____

Gender: □ *Male* □ *Female*

● Please enter **Parent/Legal Guardian*** information:

Full Name: _____

Address: _____

_____

Date of Birth: _____/_____/_____

Medical Record #: M _____

Social Security #: _____-_____-_____

Gender: □ *Male* □ *Female*

Former Name(s) - e.g. maiden name: □ N/A _____

Relationship to patient: □ *Birth Parent* □ *Adoptive Parent* □ *Legal Guardian* □ *Other* (specify): _____

***Note: Access to minor's online record is only available to birth/adoptive parents or individuals with legal guardianship. Proof of guardianship must be provided / kept on file in Health Information Management.**

Do you (parent/legal guardian) have an active MyCMH Care Portal account?

□ Yes – *please read and sign below*

□ No / Don't Know – *You must request your own MyCMH Care Portal user name and password before requesting proxy access. Please contact the Patient Portal Liaison at (410) 535-8396.*

I understand that as the minor's proxy I will have the same access and privileges that I have for my personal MyCMH Care Portal account. I also understand that additional information may be made available to me through the patient portal as Calvert Memorial Hospital continues to enhance this product.

By signing this authorization, I am requesting that Calvert Memorial Hospital give me proxy access to the above named minor's health record on the MyCMH Care Portal. I understand that I will continue to have this proxy access until the minor turns age 18 (adult) or becomes legally emancipated. Proxy access must be requested and approved once minor becomes a legal adult.

This authorization is valid until revoked by me, the minor becomes emancipated, or until the minor turns age 18 (automatically revocation). I understand that a written request is necessary to revoke or cancel this authorization prior to the minor turning age 18 (adult). However, I understand that revocation will not be effective as to uses and/or disclosures already made in reliance upon this authorization. I realize that the information used and/or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by federal privacy laws.

I have read and understand the requirements and procedures for accessing my child's medical record information online as provided in the document titled *MyCMH Care Portal Proxy Access Procedures*. I certify that I am the birth/adoptive parent or legal guardian of the minor listed above and that all information I have provided is correct. I hereby request access to the minor's online record.

_____ _____

Date Birth/Adoptive Parent or Legal Guardian Signature

_____ _____

Date Witness Signature