

Request for Proxy Access to MyWakeHealth for Individual with Diminished Mental Capacity

Required information about the patient:

Last Name: _____	First Name: _____	Middle Name: _____
<i>(As appropriate)</i> Maiden Name: _____		
Date of Birth (mm/dd/yyyy): _____		
Last 4 digits of social security number: _____ OR WFBMC Medical Record number: _____		
Street Address: _____		
City: _____		
State: _____ Zip: _____		

Required information about the proxy:

Last Name: _____	First Name: _____	Middle Name: _____
<i>(As appropriate)</i> Maiden Name: _____		
Date of Birth (mm/dd/yyyy): _____		
Last 4 digits of social security number: _____ OR WFBMC Medical Record number: _____		
Street Address: _____		
City: _____		
State: _____ Zip: _____		
Phone number with area code: (____) _____		
Email address: _____		

Required documentation:

Provide either:

A copy of the court order appointing guardian and Letters of Guardianship verifying the requester's status as permanent legal guardian of the patient.

--OR--

Durable Power of Attorney for Healthcare and physician certification verifying the patient lacks decisional capacity.

--OR--

For patients 17 years and under: provider certification that the patient lacks decisional capacity is present in Wake One AND parent or legal guardian completion of this document

Expiration:

This authorization does not expire for a patient who is 18 years of age or older unless physician certification is provided indicating that the patient has regained decisional capacity. For a patient who is 17 years of age or younger, this form will expire when the patient turns 18 years of age.

Proxy Signature: _____

Date: _____

