Atrium Health
Wake Forest Baptist

Adult Patient Authorization Granting MyWakeHealth Proxy Access to Another Adult

This authorization must be completed by adult patients (18 years or older) to grant proxy access to Atrium Health Wake Forest Baptist's patient portal, MyWakeHealth, to another individual. This proxy access will permit the designated individual to access protected health information of the patient.

Information may include medical information related to the diagnosis and/or mental illness, alcohol/substance abuse, sexually transmitted infections including HIV or AIDS test results, developmental disabilities and genetic testing results.

The individual authorized to have proxy access is not covered under HIPAA and is not subject to federal health information privacy laws. This individual could further disclose health information and it may no longer be protected by privacy regulations.

I understand that if the person that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization to the extent allowed by law.

I understand I may revoke this authorization at any time by sending a notice of revocation in writing to the Privacy Office and by terminating proxy access in the MyWakeHealth application. I further understand that I may not revoke this authorization to the extent that action has been taken in reliance on this authorization. Information about the right to revoke has been shared with me in the Atrium Health Notice of Privacy.

The individual receiving proxy access to MyWakeHealth will be required to accept and abide by the MyWakeHealth terms and conditions. In addition, Atrium HealthWake Forest Baptist may terminate the proxy access at any time without notice.

Required information about the patient:

Last Name: _____ First Name: _____ Middle Name:_____

(As appropriate) Maiden Name: _____

Date of Birth (mm/dd/yyyy): _____

Last 4 digits of social security number: _____ OR AHWFB Medical Record number: _____

Street Address: _____
City: _____
State: _____ Zip: _____

Phone number with area code: _(___)_____

Email address: _____

Required information about the individual being granted proxy access:

Last Name: _____ First Name: _____ Middle Name:_____

Date of Birth (mm/dd/yyyy): _____

Last 4 digits of social security number: _____ OR AHWFB Medical Record number: _____

Street Address: _____
City: _____
State: _____ Zip: _____

Phone number with area code: _(___)_____

Email address: _____

Expiration:

This authorization expires _____, or one year from the date of my signature.

Patient Signature: _____

Date: _____