WEST RIVER HEALTH SERVICES®

Follow My Health

Adult Proxy Form

Fill out this form to give someone else access to your FollowMyHealth record. This person is called your Proxy. This form may be completed at any West River Health Services (WRHS) location when you are able to sign in the presence of a WRHS employee. You may also mail this document to us with a copy of your driver's license as proof of identity. Mail your form to: West River Health Services, 1000 Hwy 12, Hettinger, ND 58639

About the Patient: (All sections required-please print clearly)

Name (last, first, middle initial):_____Date of Birth_____
Last 4 digits of Social Security Number:_____Phone Number:_____
Email:_____

About the Proxy: (All sections required-please print clearly)
Comple for the person getting access to the Patient's FollowMyHealth record.

Name (last, first, middle initial):_____Date of Birth_____
Last 4 digits of Social Security Number:_____Phone Number:_____
Email:_____
Street Address:_____City:_____
State:_____Zip:_____

I ask that my Proxy (whose name is above) have access to my complete medical and/or health insurance record including FollowMyHealth. I understand the data in FollowMyHealth my include medical, billing and insurance information. I also give consent for my Proxy to do these things for me:

- See and send messages to my healthcare team or insurance.
- Update my name, other personal data and payment or insurance details.

I understand and agree:

- My Proxy may have access to behavioral health and alcohol or drug treatment records and/or claims.
- Records given to my Proxy may be given to others and no longer protected.

Naming a Proxy is my choice and not required. I do not have to give this consent. I will receive care even if I do not sign this consent. I understand that if I do not sign this, access will not be given to my Proxy. If I am over 18, this consent expires 5 year from the date of my signing. If I am a minor, it will expire when I turn 18.

I may take away consent by mail to the address above or by calling 701-567-4561. I understand that if I take away consent, my Proxy's access to my health record will end. I understand this will not prevent the release of data already given. I have read and understand this form.

_____

Signature of Patient (or authorized person)(Required) Relationship to Patient Date