

## AUTHORIZATION FOR PROXY ACCESS TO PORTAL

(Please print)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
City State ZIP

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

**FOR OFFICE USE ONLY**

Identity of Patient Verified: (Initials of Facility Representative) \_\_\_\_\_ Patient's Medical Record No. / EPI: \_\_\_\_\_

### Please select ONE Portal:

LiveWell (mobile app/LiveWell.aah.org)     myBayCare (www.baycare.net/myBayCare) As used herein, the term "portal" shall refer to the particular portal selected above.

### Please select ONE:

- I want to sign up for a portal account, and to authorize a proxy to access my health information.
- I already have a portal account, and want to authorize a proxy to access my health information.
- I do not want to sign up for a portal account for myself, but want to sign up a proxy.

## Proxy Authorization 1

I authorize the following individual to participate in the portal as my proxy:

(Please print)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
City State ZIP

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Female     Male    Relationship: \_\_\_\_\_

**FOR OFFICE USE ONLY**

Identity of Proxy Verified: (Initials of Facility Representative) \_\_\_\_\_ Proxy's Medical Record No. / EPI: \_\_\_\_\_

## Proxy Authorization 2

I authorize the following individual to participate in the portal as my proxy:

(Please print)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
City State ZIP

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Female     Male    Relationship: \_\_\_\_\_

**FOR OFFICE USE ONLY**

Identity of Proxy Verified: (Initials of Facility Representative) \_\_\_\_\_ Proxy's Medical Record No. / EPI: \_\_\_\_\_

I understand that my proxy will have the **same access** and **privileges** that I have or would have as a Portal account user. I understand that this allows my proxy online access to my personal health information maintained by Advocate Aurora Health and/or BayCare Clinic which may contain protected health information created by Advocate Aurora or entities contracted with Advocate Aurora (such contracted entities can be found at the following [aurora.org/ouraffiliates](http://aurora.org/ouraffiliates)). I also understand that messages that are sent to my health care provider by my proxy may become part of **my** medical record and that all entries should be truthful, accurate and concerning **my** health issues.

**I understand that all messages sent on my behalf should be non-urgent. For any urgent issues requiring immediate response, my health care provider should be called or I will be taken to the emergency department of a local hospital or 911 will be called.**

I understand that through the portal, my proxy may be able to:

- View clinical information, such as provider notes, after visit summaries, allergies, medications, diagnostic test results and history information including records from other affiliates noted above that may share an electronic record with Advocate Aurora/BayCare Clinic. This may include genetic test results, HIV test results, and information regarding mental illness, alcohol/drug abuse, AIDS related illness and developmental disabilities.
- Make, review and cancel appointments for me
- Communicate with my health care provider via secure messaging regarding my medical care concerns
- Request my prescription refills
- View and make payments on my billing statements which may include mental health and alcohol/drug abuse services (only available through LiveWell).

*I understand that additional past, present and future information and features may be available to my proxy through the portal, when they are generally made available to other users of the portal, including other diagnostic test results or visit notes.*

I am requesting this access so my proxy may help me with my health care decisions and take a more active role in my health care. I understand that any communication with providers through the portal deals with only **my** health care issues and not those of my proxy, family members or friends. To effectively participate in **my** health care, **my** proxy may send and receive health information about other health conditions/issues not available through the portal.

I understand that if I participate in Advocate Aurora's Family Billing linked accounts and then authorize a proxy, I will inadvertently disclose the billing statement information of others on the shared account to that proxy(s).

I understand that my proxy will need to create a unique user ID and a password. The user ID and password will give my proxy access to my personal health information. Any of my health care providers have the right to deactivate access to the portal for any reason.

By signing this authorization, I am requesting that my proxy be given access to the portal. I understand that my proxy will be required to sign an acknowledgement and agree to Terms and Conditions for use of the portal. I understand that processing of my proxy's access to the portal may take 5-7 business days after the proxy's acknowledgement is received.

This authorization is valid until I revoke it. I understand that a written request is necessary to revoke or cancel this authorization. *[Please send your written revocation request to the address below.]* 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 law. I understand that I do not need to sign this authorization in order to receive treatment.

I understand that I have the right to inspect or obtain copies of the information being authorized for disclosure to my proxy by reviewing what is available in my web portal account or by contacting the medical record department where I receive services.

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Signature of Patient

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Date

**Please mail this form to:** Advocate Aurora Health - Health Information Dept.  
P.O. Box 090996, Milwaukee, WI 53209-0996

**Or Fax to:** 262-693-4480 • **Email address:** LiveWellSupport@aaah.org • **Phone number:** 1-855-624-9366