myLoyolaSelectSelect
Proxy Access Authorization Form ("Proxy Authorization")

I authorize the LUHS Information Systems staff to provide access to my Proxy; and, the disclosure of my personal health information available through myLoyolaSelect account ("myLoyolaSelect Information") to my Proxy for the purpose of assisting in my health care. I understand and acknowledge that this may include information related to my general medical care, mental health treatment, drug/alcohol abuse treatment, HIV/AIDS, and/or genetic testing. I understand that my Proxy should obtain my consent prior to re-disclosing myLoyolaSelect Information, however, myLoyolaSelect Information disclosed to my Proxy may be re-disclosed by my Proxy and will no longer be subject to federal and state health information privacy laws.

I understand the following: 1) I may view my Proxy's access to myLoyolaSelect Information by logging in to myLoyolaSelect and choosing My Medical Record then selecting Who's Accessed by Record?; 2) I have the right to revoke this Proxy Authorization at any time by contacting LUHS Information Systems staff at myloyolanotify@lumc.edu; 3) If I revoke this Proxy Authorization, my Proxy will no longer be able to access myLoyolaSelect Information; 4) My revocation will not apply to any myLoyolaSelect Information already disclosed to my Proxy and to any uses and disclosures of information that are described in the Loyola University Health System Notice of Privacy Practices; and, 5) LUHS has the right to revoke my and my Proxy's access at any time.

By providing the below Proxy information, I represent that I have permission to provide this information to LUHS. I agree to hold harmless and indemnify LUHS for any damages, liability, debts, fines or attorney's fees that LUHS may incur as a result of: My disclosure of my Proxy's information to LUHS; my Proxy's misuse of myLoyolaSelect Information; and, for my and my Proxy's failure to abide by the myLoyolaSelect Terms and Conditions of Use. I understand that LUHS will not condition treatment on my signing or not signing this authorization and that this authorization will expire upon any of the following: My or my Proxy's request to revoke my or my Proxy's access or upon LUHS' revocation of such access.

_____ _____
Date Patient Signature

_____ _____
Date Witness Signature

Please enter *your* information. LUHS Medical Record Number: _____
Name: _____ Gender: _____ Male _____ Female
Address: _____ Date of Birth: _____
City/State_____ Last Four Digits of Social Security Number: _____
E-mail: _____ Phone Number: _____

Please enter your *Proxy's* information. LUHS Medical Record Number: _____

Name: _____ Gender: _____ Male _____ Female
Address: _____ Date of Birth: _____
City/State _____ Last Four Digits of Social Security Number: _____
E-mail: _____ Phone Number: _____