myLoyolaSelectSelect
Special Proxy Access Authorization Form ("Special Proxy Authorization")

I[1] authorize the LUHS Information Systems staff to provide access to me; and, I authorize the disclosure of the below Patient's personal health information available through myLoyolaSelect account ("myLoyolaSelect Information") to me for the purpose of assisting in the Patient's health care. I understand and acknowledge that this may include information related to the Patient's general medical care, mental health treatment, drug/alcohol abuse treatment, HIV/AIDS, and/or genetic testing. I understand that I should not re-disclose myLoyolaSelect Information unless legally permitted to do so and the myLoyolaSelect Information disclosed by me, if re-disclosed, will no longer be subject to federal and state health information privacy laws.

I understand the following: 1) I may view access to the Patient's 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 Special Proxy Authorization at any time by contacting LUHS Information Systems staff at myloyolanotify@lumc.edu; 3) If I revoke this Special Proxy Authorization, I will no longer be able to access the Patient's myLoyolaSelect Information; 4) My revocation will not apply to any myLoyolaSelect Information already disclosed to me 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 access at any time.

By signing this Special Proxy Authorization, I represent that I have the legal right to gain access to the Patient's myLoyolaSelect Information. 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 access to the Patient's myLoyolaSelect Information; my misuse of myLoyolaSelect Information; and, for my failure to abide by the myLoyolaSelect Terms and Conditions of Use. I understand that LUHS will not condition treatment for the Patient on my signing or not signing this authorization and that this authorization will expire upon any of the following: My request to revoke my access or upon LUHS' revocation of such access.

_____ _____
Date Patient Representative's Signature

_____ _____
Date Witness Signature

Please enter the Patient'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: _____

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: _____

[1] Legal guardians must submit a copy of legal documentation verifying the individual's status as legal guardian.