INTEGRIS HEALTH

ADULT PROXY REQUEST

Access to Another Adult's INTEGRIS & Me Record

To request proxy access to the INTEGRIS & Me record of an adult, please complete this form. The patient or their legal representative must sign this form and provide authorization for release of medical information in INTEGRIS & Me on the "Authorization for Release of Medical Information to Adult Proxy." Please note that the patient's chart will be accessed through your (the proxy's) INTEGRIS & Me record. Completing this form will establish a INTEGRIS & Me record for you and for the patient. Please provide a government-issued ID for identity verification when submitting this form. *Attach a copy of guardianship papers, power of attorney or Advance Directive of patient as applicable.*

Return forms to your INTEGRIS Health care provider. If you don't have an INTEGRIS provider, please submit to: INTEGRIS Health Information Department, Release of Information, 3433 N.W. 56th Street, Building B, Suite C50, Oklahoma City, OK 73112.

YOUR PROXY INFORMATION (All Sections Required - Please Print Clearly)
This section should be completed by the individual requesting access to another adult's INTEGRIS & Me record.

NAME – *LAST, FIRST, MIDDLE INITIAL* ☐ *Male* ☐ *Female*		DATE OF BIRTH	Social Security Number
STREET ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER ☐ *Home* ☐ *Work* ☐ *Cell*	EMAIL ADDRESS		

PATIENT'S INFORMATION (All Sections Required - Please Print Clearly)
Complete this section with information about the patient whose INTEGRIS & Me record you are requesting to access.

NAME – *LAST, FIRST, MIDDLE INITIAL* ☐ *Male* ☐ *Female*		DATE OF BIRTH	LAST 4 NUMBERS OF SSN
STREET ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER ☐ *Home* ☐ *Work* ☐ *Cell*	EMAIL ADDRESS		

INTEGRIS & Me TERMS and AGREEMENT

- I understand that INTEGRIS & Me is intended as a secure online source of confidential medical information. If I share my INTEGRIS & Me ID and password with another person, that person may be able to view health information about someone who has authorized me as an INTEGRIS & Me proxy.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.
- I understand that INTEGRIS & Me contains selected, limited medical information from a patient's medical record and that INTEGRIS & Me does not reflect the complete contents of the medical record.
- I understand that my activities within INTEGRIS & Me may be tracked by computer audit and that entries I make may become part of the patient's medical record.
- I understand that access to INTEGRIS & Me is provided by INTEGRIS Health as a convenience to its patients and that INTEGRIS Health has the right to deactivate access to INTEGRIS & Me at any time for any reason. I understand that use of INTEGRIS & Me is voluntary, and I am not required to use INTEGRIS & Me or to authorize a INTEGRIS & Me proxy.
- If the proxy's legal relationship with the patient changes, INTEGRIS Health must be informed immediately by sending written notice to your INTEGRIS health care provider.

By signing below, I acknowledge that I have read and understand this INTEGRIS & Me sign-up document and the attached Terms and Conditions, and attest that I am the authorized proxy of the patient.

YOUR (PROXY) SIGNATURE	DATE
PRINTED NAME	RELATIONSHIP TO PATIENT

I acknowledge that I have read and understand this INTEGRIS & Me sign-up document. I agree to its terms and choose to designate the person named above as my INTEGRIS & Me Proxy, thereby allowing them access to my INTEGRIS & Me Medical Record.

PATIENT SIGNATURE (OR AUTHORIZED PERSON)	DATE
PRINTED NAME	RELATIONSHIP TO PATIENT

Patient Label
Patient Name:
MRN:
DOB:

NS-0319 Release of Information
Rev 11/21, 4/22

INTEGRIS HEALTH

Authorization for Release of Medical Information to Adult Proxy

This form is an authorization that will permit INTEGRIS Health to release your medical information to your designated adult proxy. Please read it carefully.

This form should be completed by the patient who is authorizing another adult to access medical information in his or her INTEGRIS & Me record. It must accompany the Adult Proxy Form, which provides the name and information of the individual who the patient is authorizing to access their INTEGRIS & Me record as a proxy.

PATIENT NAME – *LAST, FIRST, MIDDLE INITIAL*	◯ *Male* ◯ *Female*	DATE OF BIRTH	LAST 4 NUMBERS OF SSN

I am requesting that _____ *(insert name of proxy)* receive access to my health information that is available in my INTEGRIS & Me Record. This person is my designated INTEGRIS & Me proxy. I authorize INTEGRIS Health to release the health information contained in my INTEGRIS & Me record to my INTEGRIS & Me proxy. I understand that the medical information in INTEGRIS & Me is obtained from my electronic medical record and may include information from other INTEGRIS Health facilities. I authorize release of any information contained in my INTEGRIS & Me medical record held by INTEGRIS Health to my designated proxy.

I authorize release of this information only through my INTEGRIS & Me record. This form does not authorize release of my medical record to my designated proxy by other methods or in other forms.

I understand that once information has been disclosed, it potentially may be re-disclosed by the proxy and the disclosed information may not be covered by federal privacy protections.

Participation in INTEGRIS & Me and designating a INTEGRIS & Me proxy is completely voluntary. I understand that I am not required to designate a INTEGRIS & Me proxy and I am not required to provide this authorization. I also understand that INTEGRIS Health does not condition any of my health care treatment, payment or other services on whether I provide this authorization. However, I also understand that if I do not provide authorization, INTEGRIS Health is not permitted to provide access to my INTEGRIS & Me record to my designated proxy.

This authorization will expire upon revocation, or on the date or event specified here _____. I also may revoke this authorization at any time by providing a written request for revocation to INTEGRIS Health.
I understand that if I revoke this authorization, my designated proxy's access to my INTEGRIS & Me record will be ended. I also understand my revocation will not affect any disclosures that were made prior to processing the revocation request.

PATIENT SIGNATURE (OR AUTHORIZED PERSON)	DATE
PRINTED NAME	RELATIONSHIP TO PATIENT

If person other than the patient signs, indicate authority to sign for patient (e.g., guardian) and attach documentation:

The completed form may be faxed to INTEGRIS Health Information Management at 405-552-8773, mailed to 3433 NW 56th Street, Bld. B Ste. C50 Oklahoma City, OK 73112, or emailed to Healthinfomanagement@integrishealth.org. For questions, call 877-778-7211.

Patient Label
Patient Name:
MRN:
DOB: