LEHIGH VALLEY HOSPITAL
LEHIGH VALLEY HOSPITAL - POCONO
LEHIGH VALLEY HOSPITAL - HAZLETON
LEHIGH VALLEY HOSPITAL - SCHUYLKILL

PLACE PATIENT LABEL HERE

ADULT PROXY FORM

Both the patient, or patient's authorized representative, who is granting access to the patient's MyLVHN / MyChart Bedside and the Proxy (person requesting access to the patient's MyLVHN/MyChart Bedside) agree to the following:

- **I understand that MyLVHN/MyChart Bedside are not to be used for medical emergencies or urgent situations.**
- I understand that MyLVHN Proxy allows the patient or patient's representative to grant another person ("Proxy") to have access through the MyLVHN Portal to the patient's personal health information.
- MyChart Bedside Proxy will allow the Proxy to access the patient's personal health information while hospitalized.
- The information disclosed in MyLVHN/MyChart Bedside will enable the Proxy to play a more active role in the patient's healthcare. I understand that additional information may be made available as MyLVHN/MyChart Bedside continues to evolve, and that I have agreed to the terms and conditions provided upon my MyLVHN/MyChart Bedside account activation. I understand that if the patient or authorized representative no longer wishes to allow the Proxy to access MyLVHN/MyChart Bedside due to additional information being included, then the patient or authorized representative can revoke the Proxy's access at any time as described below.
- I understand that activities within MyLVHN/MyChart Bedside are tracked by computer audits and that entries made by the patient or Proxy may become part of the patient's medical record. This excludes patient or Proxy entered notes that are viewable only by the patient or Proxy.
- I understand that a written request must be made by the patient or patient's authorized representative to cancel or revoke this authorization and that any actions taken or access prior to cancellation was authorized by the patient's signature below. The patient or authorized representative may also revoke this proxy access at any time, via the My Family's Records - Family Access Settings in the patient's MyLVHN account.
- I understand that Lehigh Valley Health Network has the right to revoke access to MyLVHN/MyChart Bedside at any time for abusive use of the system.
- I understand that Proxy access is granted as a means to participate in the healthcare of the adult patient listed in the "Adult Proxy Form" and direct access to their account is not allowed. I also acknowledge that if the adult patient has problems logging into their own MyLVHN/MyChart Bedside account, they must contact support to gain access and that Lehigh Valley Health Network MyLVHN support can only respond to the account holder for account inquiries.

(This form must be completed in the presence of a Lehigh Valley Health Network staff member.)

I hereby authorize (Proxy full name) ____ to access my protected health information using MyLVHN/MyChart Bedside, and have the ability to act on my behalf via MyLVHN/MyChart Bedside, as indicated in the "Adult Proxy Form (Adult to Adult)" document. I may revoke this proxy access any time I wish, by means of my personal MyLVHN Account and/or MyChart Bedside Account.

X ____ ____________________ ____________

Patient Signature **Date (Month/Day/Year)** **Time**
(Patient or Authorized Representative Granting Access)

I have read and understand the requirements and procedures for accessing a patient's medical record information online as provided above and agree to act as a Proxy for the above mentioned patient.

X ____ ____________________ ____________

Proxy Signature (Person Requesting Access) **Date (Month/Day/Year)** **Time**

X ____ ____________________ ____________

Witness Signature **Date (Month/Day/Year)** **Time**

LEHIGH VALLEY HOSPITAL
LEHIGH VALLEY HOSPITAL - POCONO
LEHIGH VALLEY HOSPITAL - HAZLETON
LEHIGH VALLEY HOSPITAL - SCHUYLKILL

PLACE PATIENT LABEL HERE

ADULT PROXY FORM

Please fill out all of the required information below in order to have the proxy access created.

☐ **MyLVHN Portal**
☐ **MyChart Bedside**

Proxy Information – Individual Requesting Access to a MyLVHN/MyChart Bedside Account:

Full Name:____

Address:____

City:______________________________ **State:**____________ **Zip Code:**__________

Phone Number: (______) ______________________ **Date of Birth (MM/DD/YYYY):**__________________

Social Security Number (XXX-XX-XXXX):____________________________

Email Address:____

Relationship to patient: ☐ **Son** ☐ **Daughter** ☐ **Spouse** ☐ **Power of Attorney** ☐ **Other**

If 'Other.' please specify:____

Patient Information – Individual Granting Access to a MyLVHN/MyChart Bedside Account:

Full Name:____

Address:____

City:______________________________ **State:**____________ **Zip Code:**__________

Phone Number: (______) ______________________ **Date of Birth (MM/DD/YYYY):**__________________

Social Security Number (XXX-XX-XXXX):____________________________

Office Use Only

Patient's Medical Record Number:

☐ **Proxy Accounts Linked**

☐ **Form Scanned**