Access to another Guthrie Adult Patients Medical Record via eGuthrie
(Designated Adult Authorization Form)

Requirements and Procedures

Designated adults can access the online medical record of a Guthrie patient if the patient authorizes.

Requirements for online access to a patient's record:

- Individual requesting access must have signed consent from the patient
- Designated Adult Authorization Form must be completed and signed
- Each caregiver requesting access must have their own *e*Guthrie account.

I understand that:

- I must have a *e*Guthrie account
- I must log in to *e*Guthrie with my own User ID & Password
- I must click on 'View Other Records' to access a patient's online record
- I agree to abide by the terms and conditions on the *e*Guthrie site

Designated adults access to a patient's record is revoked when the patient or physician submits a request or revokes access online. Guthrie reserves the right to revoke online access to medical information at any time.

Communications on behalf of the patient must be sent from the patient's record and responses will be received in the patient's record. *e*Guthrie email alerts will be sent to the email address entered in the patient's record.

If you have an *e*Guthrie account, you will receive a *e*Guthrie message when access to the patient's record is available, typically 1 to 3 business days after completed authorization form is received.

GUTHRIE

Designated Adult Authorization Form

Please enter **Patient's** information below:

Patient's Name: _____ Guthrie Medical Record #: _____

Address: _____ Last 4 digits of Social Security #: _____

_____ Date of Birth: _____

Gender: ____ Male ____ Female

To be notified when new messages about the patient's care are sent to *e*Guthrie, please list an email address:

_____

I agree to allow the designated adult, named below, *e*Guthrie access to my medical information currently available and that may become available as a result of future medical care. I understand I may revoke this access at any time.

_____ _____

Date Patient Signature

Please enter information below:

Designated Adult Name: _____ Guthrie Medical Record #: _____

Address: _____ Last 4 digits of Social Security #: _____

_____ Date of Birth: _____

Gender: ____ Male ____ Female

Former Name(s) - e.g. maiden name _____

If Other, please specify: _____

Please note: If you are a Guthrie patient you must activate your account prior to requesting proxy

I have read and understand the requirements and procedures regarding accessing a patient's medical record information online as provided on the document titled Designated Adult Access to the Online Medical Record of a Guthrie Health Patient via *e*Guthrie.

Completed forms can be submitted in person or via mail to your or your family's Guthrie caregiver. For mailing addresses, please reference our Guthrie website.

_____ _____

Date Signature