PROXY DESIGNATION AND AUTHORIZATION FOR MYASPIRUS

I hereby designate ______________________as my PROXY and authorize the following access to my MyAspirus account:

- ☐ **FULL ACCESS** ***(Choose only one)***
- ☐ **READ ONLY ACCESS**

If you would like notification of when granted access is completed, please provide your email address here: ____

Please complete this document and submit it via one of the methods below:
Email: Aspirushealthinformation@aspirus.org
Fax: 715-847-2187
Mail: Aspirus Health Information Management 333 Pine Ridge Blvd., Wausau, Wisconsin 54401

TERMS AND CONDITIONS

These terms and conditions apply to FULL ACCESS:

I understand that by allowing FULL ACCESS, I authorize my PROXY to:

1) See and access the same medical information that I am able to on MyAspirus; and
2) Perform all of the functions MyAspirus allows me to perform including, but not limited to, the ability to schedule and cancel appointments, communicate with Providers, provide responses to questionnaires, and request medication refills.

I further understand that Aspirus does not restrict my PROXY's FULL ACCESS to MyAspirus in any manner.

These terms and conditions apply to READ ONLY ACCESS:

I understand that by allowing READ ONLY ACCESS, I authorize my PROXY to: see and view the information available on the MyAspirus account.
I understand that with READ ONLY ACCESS, my PROXY will not be able to utilize or operate any of the functionality available on MyAspirus. My PROXY will not be able to schedule or cancel appointments, communicate with Providers, respond to questionnaires or request medication refills. I understand that other than as stated above, Aspirus does not restrict my information viewable to the PROXY via READ ONLY ACCESS.

These terms and conditions apply to both FULL ACCESS and READ ONLY ACCESS:

- **WRITTEN REQUEST FOR REVOCATION**: I understand that I may revoke this authorization and PROXY designation at any time but must do so by delivering a written request for revocation to Aspirus Health Information's contact options above. I understand that it may take up to ten (10) business days for the revocation to be processed. I agree to hold Aspirus, Inc. and its subsidiaries and affiliates harmless against any disclosures of medical information made prior to a processed revocation.
- I understand that information disclosed to my PROXY pursuant to this authorization may be subject to redisclosure by my PROXY and no longer protected by HIPAA and related state and federal law.
- I understand that my treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I allow PROXY access pursuant to this authorization.

 You are entitled to a copy of this authorization after you sign and complete it.

BOX A	REQUIRED INFORMATION/SIGNATURES

The information in Box A must be provided in full for all PROXY ACCESS requests.

PATIENT	PROXY
Name:______________________________	Name: ______________________________
Date of Birth:________________________	Date of Birth:_______________________
Address:____________________________	Address:___________________________
____________________________	____________________________
Signature:__________________________	Signature:__________________________
Date:______________________________	Date:_____________________________

(If the patient is an adult, only Box A needs to be completed.)
(If the patient is incapacitated or incompetent, see Box B below.)
(If the patient is a minor, see Box C below.)

BOX B	SIGNATURE FOR INCOMPETENT/INCAPACITATED PATIENT

If the patient is incapacitated or incompetent and not capable of signing, the patient's Agent or Guardian <u>must also</u> complete this section.

Signer's relationship to patient (Health Care Agent or Legal Guardian) (circle one)

Signature of Agent or Guardian:

► ____________________________________

(Note: Agent or Guardian may grant either type of ACCESS to self. Provide all patient and PROXY information above. Aspirus may require proof of your status as Health Care Agent or Legal Guardian.)

BOX C	SIGNATURES FOR MINOR PATIENT

If the patient is a minor, complete this section.

- To authorize READ ONLY ACCESS or FULL ACCESS to a Parent or Person with legal custody, only one (1) Parent or Person with legal custody needs to sign.
- To authorize READ ONLY ACCESS to any third party, only one (1) Parent or Person with legal custody of the minor needs to sign.
- To authorize FULL ACCESS to any third party, all Parents or Persons with legal custody of the minor must sign.
- When minor turns 18, PROXY ACCESS (whether READ ONLY or FULL ACCESS) shall automatically terminate.
- State law allows certain minors to block access to certain medical information despite this PROXY ACCESS.

PARENT/LEGAL CUSTODIAN	PARENT/LEGAL CUSTODIAN
Name:______________________________	Name:
Address:____________________________	Address:______________________________
Signature:__________________________	Signature:______________________________
Date:______________________________	Date:__________________________________
Relationship to Minor Patient:_____________	Relationship to Minor Patient:_____________

You are entitled to a copy of this authorization after you sign and complete it.