HealthPartners Adult Proxy Request
MS 24403A
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Minneapolis, MN 55440-1490

healthpartners.com

HealthPartners Park Nicollet

HealthPartners Online Proxy Access Authorization

Patient's Information – *whose patient record will be shared?*

Legal First Name	**Legal Middle Name**	**Legal Last Name**
Address	**City**	
State	**Zip Code**	**Daytime Phone Number**
Date of Birth	**Gender** M F	**Medical Record Number**

Proxy's Information – *who can access the patient's record?*

Legal First Name	**Legal Middle Name**	**Legal Last Name**
Address	**City**	
State	**Zip Code**	**Daytime Phone Number**
Date of Birth	**Gender** M F	**Medical Record Number**

By signing this form, I understand that:

1. I am authorizing HealthPartners to disclose (give out) my information to this individual.
2. This authorization relates only to HealthPartners online accounts.
3. All information accessible through my online HealthPartners account will become accessible to this individual.
4. This authorization expires (ends) 10 years from the date access is granted.
5. I may revoke this authorization at any time by notifying, in writing, the address listed above.
6. Revoking this authorization does not apply to information already released under this authorization.
7. Federal privacy laws protect information disclosed to a covered healthcare provider or health plan.
8. Information disclosed to other persons or entities may not be protected and may be re-disclosed.
9. I do not have to sign this form. Treatment will still be provided to me if I do not sign this form. Payment for services is not contingent upon me signing this form, unless those services are for the sole purpose of creating personal information for a third party, such as life insurance companies.

Patient's Signature: _____ Date: _____

Mail signed and completed form to the address above.

Our mission is to improve health and well-being in partnership with our members, patients and community.