CoxHealth

Authorization for CoxHealth Express

Patient Information:

Patient Name: _____ **Patient DOB**: _____

Patient's Social Security Number: _____ **Patient Phone**: _____

Patient Mailing Address: _____

Patient's Primary Care Physician: _____

Parent/Guardian Information:

Parent/Guardian Name: _____ **Parent/Guardian Phone:** _____

Relationship to patient: _____ **Parent/Guardian DOB:** _____

Parent/Guardian Social Security Number: _____

Delegate Information:

Delegate Name: _____ **Delegate's DOB:** _____

Delegate Social Security Number: _____ **Delegate Phone:** _____

TO MY HEALTHCARE PROVIDERS—I am utilizing this authorization form for the following scenario (please check the corresponding box):

- ☐ **Request for my CoxHealth Express account to be activated**
  I am unable to be present at my health care provider's office in order to have my account activated. I understand that I may set up my account, and the clinic will connect my chart upon receipt of this form, and verification of signature
- ☐ **Request to have access to my child's medical record through CoxHealth Express**
  I am unable to be present at my child's health care provider's office in order to connect my child's medical record to my CoxHealth Express account. I understand that this connection will be made upon the receipt of this form and verification of signature. I further understand that if my minor child is 13 or over, they will be required to sign the *Notice to Minor Patients of Right to Restrict Access to Certain Medical Information* before access will be granted.
- ☐ **Authorization of another party to have access to my child's medical record through CoxHealth Express**
  I understand that granting access to my child's medical chart via CoxHealth Express is authorizing this delegate to have access to my child's medical records. The access to my child's medical record will continue until I remove their access by signing a *CoxHealth Express Revocation* form, or until the minor child reaches the age of 18.
- ☐ **Delegate access of my CoxHealth Express account to my representative(s)**
  (You will NOT have a CoxHealth Express account of your own—your chart will be managed through your delegate's CoxHealth express account)
  I understand that granting access to my medical chart via CoxHealth Express is authorizing my delegate to have access to my medical records.

I further understand:

- I do not have to sign this authorization, but understand that not doing so will mean I will not have access to my medical record electronically. I will still have access to my medical record by paper request.
- My refusal to sign will not affect my ability to obtain treatment from my healthcare provider(s) or my eligibility for healthcare benefits.
- By granting delegate access to my medical record via CoxHealth Express, I understand that they may have access to my (or my child's) past, present, and future health and billing information. This access may include complete health and billing records including, but not limited to, pertinent documentation, history and physical, discharge summary, photographs, videotapes, operative reports, consultation reports, x-ray reports, lab results, progress notes, EKG, EEG, and x-ray films/images.
- Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to my healthcare provider(s). This authorization will remain in force and effective from the date of my signature until revoked by me in writing.
- Once my (or my child's) health information is released to the above named person, the health information may be subject to re-disclosure and may be protected by federal or state privacy laws protecting health information.
- The entity authorized to disclose my health information will not be compensated by the recipient for disclosure, except the cost of copying and mailing as authorized by law.
- A photocopy of this authorization will be as valid as an original.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Printed Name of Patient or Legal Guardian Relationship