AUTHORIZATION FOR PROXY ACCESS TO MYCITYOFHOPE – ADULT PATIENT

By completing this form, I am authorizing another adult, also known as "Proxy", to have access to my MyCityofHope Account.

I understand that by authorizing the proxy to have access to my MyCityofHope account, the proxy will be able to view all information available now or later through MyCityofHope. This information may include, for example, clinical diagnoses, clinical procedures, histories of present illnesses, immunizations, allergies, medication information, laboratory test results including test results that may be released before I have reviewed them with my physician, physician notes, information regarding medical research and clinical trials, billing/account and insurance information and categories of information that may not be currently available through MyCityofHope. I understand that this information may also include sensitive information related to mental health screenings, HIV/AIDS, infectious disease, sexually transmitted infection, genetic testing, substance/alcohol use and treatment history, domestic violence, child abuse and family abuse. I also understand that by authorizing a proxy to have access to my MyCityofHope account, the proxy will be able to review and update my account information maintained in MyCityofHope, communicate with my health care providers with regard to my health status, and engage on my behalf, in transactions as permitted by me and my health care providers in MyCityofHope.

Patient Information

FIRST NAME	MIDDLE INITIAL	LAST NAME	DOB
MEDICAL RECORD NUMBER		PHONE NUMBER	EMAIL ADDRESS
ADDRESS	CITY	STATE	ZIP CODE

Would you (patient) like your own MyCityofHope Account?

☐ Active I already have an active MyCityofHope account

☐ Yes If yes, the above email address will be used

☐ No All email notifications of activity in your account will be sent to your proxy's email address

I hereby authorize the following person to have proxy access to my MyCityofHope account:

Patient Authorized Representative ("Proxy") Information

In order to view the patient's information, the proxy must also obtain his/her own MyCityofHope account, but does not need to be a City of Hope patient.

FIRST NAME	MIDDLE INITIAL	LAST NAME	DOB
RELATIONSHIP TO PATIENT		PHONE NUMBER	EMAIL ADDRESS
ADDRESS	CITY	STATE	ZIP CODE

General Acknowledgements

I understand that:

1. Access to treatment or services may not be denied to me if I decline to sign this authorization or revoke my authorization. However, without this authorization, City of Hope will not allow my proxy to access my MyCityofHope account.
2. I may inspect or obtain a copy of my health information at any reasonable time prior to authorizing its disclosure.
3. I may revoke this authorization at any time in writing, signed by me or my personal representative and submit to City of Hope, Health Information Management Services Department, by the delivery methods above. Such revocation will promptly take effect except to the extent that City of Hope already has acted based on this authorization and such refusal or revocation will not affect the commencement, continuation or quality of my treatment at City of Hope.

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4. Unless otherwise revoked, this authorization will automatically expire 10 years from the date signed by patient.
5. I have a right to receive a copy of this authorization.
6. Once City of Hope discloses my health information pursuant to this authorization to my designated Proxy, City of Hope cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the disclosure of my health information.
7. I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my health information in my MyCityofHope account. By my signature below I hereby, knowingly and voluntarily, authorize City of Hope to use or disclose my health information in the manner described above.

Authorization and Acknowledgement by Patient

SIGNATURE OF PATIENT | DATE | TIME

FIRST NAME | MIDDLE NAME | LAST NAME

Proxy Acknowledgement

By signing below, I acknowledge and agree that:

1. I will be using my own MyCityofHope account to access the patient's MyCityofHope account.
2. I will comply with the terms and conditions on the MyCityofHope web page (located at www.mycityofhope.org then select the Terms and Conditions link on the page) and this document.
3. Unless otherwise revoked, this authorization will automatically expire 10 years from the date signed by patient.

SIGNATURE OF PROXY | DATE | TIME

FIRST NAME | MIDDLE NAME | LAST NAME

FOR COH USE ONLY (to be completed by staff who obtained proxy form):

☐ I have given a photocopy of the signed MyCityofHope authorization form to the patient.
☐ I have viewed the patient's government issued ID on (date) _____

SIGNATURE OF COH STAFF | PRINTED NAME OF COH STAFF

PATIENT NAME | PATIENT DOB | MRN

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How to Submit Form:

Once completed, please forward to the Health Information Management Services Department the following methods below:

Please allow up to 72 hours for processing of your request. Once processed, you will receive a link to activate your MyCityofHope account.

If you have any questions regarding the status of your request, you may follow-up with our Release of Information specialist by contacting the appropriate site below.

COH - California

- **Email:** HIMS-MyCityofHope@coh.org
- **Fax:** (626) 218-8443 Attention: Health Information Management Services (ROI)
- **Mail:** Health Information Management Services (ROI)

City of Hope
1500 East Duarte Road
Duarte, CA 91010

COH - Chicago, Atlanta, Phoenix, Hospitals and Outpatient Care Centers

- **Email:** HIMSROI2@COH.ORG
- **Fax:** (847) 746-6791 Attention: Health Information Management Services (ROI)
- **Mail:** Health Information Management Services (ROI)

City of Hope
2520 Elisha Avenue
Goodyear, AZ 85338

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