FirstHealth OF THE CAROLINAS

PATIENT AUTHORIZATON - Proxy Access to my FirstHealth of the Carolinas MyChart Account

I authorize and request FirstHealth of the Carolinas to grant my authorized representative as designated below ("Authorized Representative") access to electronic protected health information, including clinical and guarantor billing information, maintained in my FirstHealth Of the Carolinas online Patient Portal record accessed through MyChart (hereafter referred to as "MyChart").

Authorized Representative (Printed Name):______________________________ **DOB:**______________

Relationship:______________________ Email:______________________________
Address:__________________________ City:_______________________________
Zip Code:______________ State:__________ Preferred Phone:____________________ Cell ☐ Home ☐

Electronic Protected Health Information in my online chart may include but is not limited to:

Hospital Admissions	Diagnostic Test Results	Medications/Allergies
Diagnoses/Procedures	Medical History	Secure Messaging
Physician/Provider Reports	Current Health Issues	Billing & Insurance

I understand that:

- Information in MyChart may include mental health, substance abuse or STD diagnosis, treatment or medications
- I may ***revoke*** this authorization at any time by contacting the Patient Privacy Office at FirstHealth of the Carolinas at 1 (866) 898-8891. Such revocation shall not affect disclosures made prior to the revocation.
- Information disclosed pursuant to the authorization may be subject to ***redisclosure*** by my Authorized Representative and may no longer be protected by the HIPAA Privacy Rule.
- This authorization is voluntary. If I do not sign or if I revoke this authorization, FirstHealth of the Carolinas will still provide treatment to me and will seek payment for services provided.
- This authorization is valid unless and until I revoke the Authorized Representative's access.
- Access to my protected health information by my Authorized Representative requires that I maintain an active online Patient Portal account.

Expiration:

I understand that by granting access to my Authorized Representative, they are required to agree to comply with Terms and Conditions required for online access. Should my Authorized Representative not accept and comply with the Terms and Conditions, I understand that FirstHealth may deny my Authorized Representative access or revoke their access to MyChart.

Signatures:

______________________________ ______________________
(Signature of Patient) *(Date / Time)*

______________________________ ______________________
(Printed Full Name of Patient) ***(Date of Birth)***

Signature Witness:______________________ **Date/Time:**________________

RETURN THIS FORM VIA E-MAIL (mychartsupport@firsthealth.org), FAX (910-235-7808), or mail to FirstHealth of the Carolinas Privacy Office PO Box 3000, Pinehurst, NC 28374