ACCESS REQUEST FOR INCAPACITATED PATIENT

PATIENT'S INFORMATION

Patient's Name: _____ Patient's Date of Birth: _____

Address:_____City:_____ State: _____ Zip: _____

Existing My Genesis account? ☐ Yes ☐ No

PROXY'S INFORMATION

Proxy's Name: _____ Proxy's Date of Birth: _____

Address:_____City:_____ State: _____ Zip: _____

Email: _____

Telephone:_____

Existing My Genesis account? ☐ Yes ☐ No

Relationship to Patient: ☐ Father ☐ Mother ☐ Spouse ☐ Legal Guardian ☐ Other

Legal documentation is required for Incapacitated Patient.

My signature represents that I have the legal right to, and am asking for access to, this patient's health information on My Genesis patient website. I understand when I first access the patient website; I will need to agree to the My Genesis terms and conditions. You will need to provide Durable Power of Attorney or other legal documentation as proof of your right to access this information. **You have the right to revoke this authorization at www.genesishealth.com/MyGenesis by completing the "Revoke Access to My Genesis" form.**

Printed Name of Proxy: _____

Signature of Proxy: _____ Date: _____

Mail Completed Form to:

Genesis Health System
Health Information Management
My Genesis Proxy Access
1227 East Rusholme Street
Davenport, IA 52803

OFFICE USE ONLY

Verified and access entered by: _____ Date: _____