ACCESS REQUEST FOR ADULT PROXY

PATIENT'S INFORMATION

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

Address:_____City:_____ State: _____ Zip: _____

Telephone:_____

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

My signature represents that I am giving access to my health record to the proxy listed above.
This authorization is voluntary. This agreement will continue until cancelled. Access can be cancelled on-line at www.genesishealth.com/MyGenesis by completing the "**Revoke Access to My Genesis**" form.

Printed Name of Patient: _____

Signature of Patient: _____ 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: _____