M20UP-123
Rev. 11/25

DukeHealth

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Authorization for Adult Proxy Access to MyDukeHealth

I authorize and request Duke University Health System* and Duke Health Integrated Practice Inc* ("Duke") to grant my designated personal representative identified below (Proxy) access to portions of my electronic protected health information, including, clinical and billing information, maintained through Duke MyDukeHealth.

Proxy Name	**Date of Birth**	**Phone**	**Email**

Street Address	**City**	**State**	**Zip Code**

Electronic Protected Health Information in Duke MyDukeHealth

Secured Messaging	Appointments	Test Results	Medications
Allergies	Immunizations	Preventive Care	Medical History
Hospital Admission	Track My Health	Billing & Insurance	My Account Letters
Diagnosis	Current Health Issues		

I Understand That

- Information to be released in Duke MyDukeHealth may include mental health, substance abuse or STD diagnosis, treatment or medications
- I may ***revoke*** this proxy authorization at any time by clicking the "Revoke access" button while logged into my Duke MyDukeHealth account, by accessing the section titled "My Account," and then opening the sub-section titled "My Family's Records, "where I will see a list titled "Who can view my record?" I can also ask my provider to revoke this access, I can call Duke Health Information Management at 919-684-1700 or I can send written notice to **DUHS Health Information Management, Box 3016, Durham, NC 27710**. Such revocation shall not affect disclosures prior to the revocation.
- Information disclosed pursuant to the authorization may be subject to ***redisclosure*** by the Proxy and may no longer be protected by the HIPAA Privacy Rule.
- This authorization is voluntary. If I do not sign or I revoke this authorization, Duke will still provide treatment to me and will seek payment for services provided.
- This authorization is valid unless and until I revoke the Proxy's access.

Expiration

I understand that Duke MyDukeHealth access is a privilege, not a right, and that my Proxy must agree to comply with the Duke MyDukeHealthTerms and Conditions. DUHS will provide my Proxy an activation code and instructions for accessing electronic protected health information about me in Duke MyDukeHealth. If my Proxy does not accept and at all times comply with the Terms and Conditions, I understand that DUHS may deny my Proxy access or revoke my Proxy's access Duke MyDukeHealth I also understand that Duke may deny my Proxy access or revoke my Proxy's accessfor any reason and at any time in Duke's sole discretion.

_____ _____

Signature of Patient Date

*All references herein to "Duke" shall refer to Duke University Health System, Inc., Duke University and any and all of its controlled affiliates, including without limitation Duke University Affiliated Physicians, Inc., d/b/a Duke Primary Care and Associated Health Services, Inc. and Duke Health Integrated Practice, Inc. and any and all of its controlled affiliates including without limitation Regional Anesthesia, PLLC and Regional Psychiatry, PLLC.

COMPLETED FORM should be returned to one of the following:

DUHS Health Information Management
Email ROI-Requestor3@dm.duke.edu
Mail to DUHS Box 3016, Durham, NC 27710
Fax to 919-620-5165

Interpreter services offered/utilized (select one):

☐ No interpreter needed (no language barrier)
☐ Facility-provided interpreter (via video)
☐ Facility-provided interpreter (in person)
☐ Facility provider/staff used (approved bilingual provider/staff member
☐ Facility-provided interpreter (via telephone)
☐ Refused – Language Waiver Obtained (>18 y/o Family or Friend)