MyHSS Proxy Access Request Form

Minor Patient/Legal Guardian

Parents and legal guardians (collectively, “Legal Guardians”) of minor (age 0-17) patients of Hospital for Special Surgery, its affiliated entities, and members of its Medical Staff (collectively, “HSS”) can obtain proxy access to the MyHSS account of such minor patients.

Requirements to establish and maintain proxy access to a minor patient’s HSS record via MyHSS:

- The Legal Guardian must complete this Form to document his/her request for proxy access for the minor patient whose information he/she requests Proxy Access for via MyHSS.
- The Legal Guardian must submit the completed form to appropriate HSS staff for processing. The HSS staff member will verify the identity (via photo ID) and status of the Legal Guardian before approving the proxy access request; provided, however, that if the Legal Guardian has been granted temporary proxy access to a minor’s MyHSS account for the limited purpose of completing pre-visit forms on behalf of the minor, such temporary access will be terminated (de-activated) if the identity and status of the Legal Guardian is not verified as noted above at the applicable visit.
- The Legal Guardian who obtains proxy access must have his/her own MyHSS account. If that individual does not have a MyHSS account at the time the request is made, HSS staff will establish a MyHSS account for that individual.

When the individual with proxy access logs into his/her MyHSS account, the following requirements will apply:

- The individual must log into MyHSS with his/her own User ID & Password;
- The individual must click on ‘View Other Records’ to access the HSS patient’s online record; and
- The individual must agree to abide by the HSS’s MyHSS Terms & Conditions of Use.

HSS reserves the right to terminate a Legal Guardian’s proxy access to MyHSS at any time.

Patient’s Name: ______________________________

Date of Birth: ______________________ Sex: Male Female Other

Address: ______________________________

Please enter the **Patient’s** information below:

Date	Time	Adolescent Child’s Signature	Adolescent Child’s Name (printed)

If you are requesting access to records on behalf of an adolescent patient (ages 12-17), the adolescent patient must sign above. (NYS Public Health Law, 17 & 18)

Proxy’s Name: ______________________ Relationship to Patient: ______________________

Date of Birth: ______________________ Sex: Male Female Other

Address: ______________________________

Please enter the **Proxy’s (Legal Guardian’s)** information below:

I hereby attest that I am a Legal Guardian of the minor Patient named above. I hereby authorize HSS to grant proxy access to me as a MyHSS Proxy for the minor Patient named above, for whom I am Legal Guardian. I understand and agree that proxy access will allow me to access the medical information of the Patient that is currently available via MyHSS and all medical information that may become available via MyHSS as a result of the Patient’s future medical care at HSS. I understand my access to MyHSS as a proxy is governed by HSS’s MyHSS Terms & Conditions of Use. I understand I may revoke this proxy access at any time by notifying HSS’s Privacy Officer in writing and that HSS may terminate my MyHSS proxy access at any time.

Date	Time	Legal Guardian’s signature	Legal Guardian’s Name (printed)