[*PLACE PATIENT LABEL HERE*]

Authorization for Third Party Access to My CS-Link Account
ADULT WITH DIMINISHED CAPACITY

This form is being completed by an adult who is responsible for health care decisions of the patient identified below ("Proxy") who wants access to portions of the Patient's electronic protected health information ("ePHI") maintained by the Cedars-Sinai Health System. The Proxy will need to show his/her photo ID. This authorization will automatically expire 5 years from the date signed by the Physician below.

Patient Information

Patient's Name: _____ DOB: _____
Medical Record Number (if known): _____ Phone: _____
Street Address:_____
City: _____ State: _____ Zip: _____

Proxy Information

In order to view the Patient's information, the Proxy must also obtain their own My CS-Link account.
Proxy's Name: _____ DOB: _____
Phone: _____
Street Address:_____
City: _____ State: _____ Zip: _____

My relationship to the Patient is as follows: _____

By signing below, I acknowledge and agree that:

- I will be using my own My CS-Link account to access the Patient's My CS-Link account.
- I will comply with the terms and conditions on the My CS-Link web page (located at https://patients.mycslink.org, then select the Terms and Conditions link on the page) and this document.
- I will keep my password confidential and not share this information with anyone.
- Communications on behalf of the Patient through My CS-Link must be sent from the Patient's record and responses will be received in the Patient's record. My CS-Link e-mail alerts will be sent to the e-mail address I supply when I activate my account.
- I authorize the Use or Disclosure of Electronic Protected Health Information.
- If I cease to be responsible for the health care decisions of the Patient, I will notify Cedars-Sinai Health System.

X_____/_____/_____/_____

Proxy Signature | Proxy Name (printed) | Date | Time

Physician Certification

Based on information provided to me**, I have determined that it is appropriate for the Proxy to have access to the Patient's My CS-Link account for purposes relevant to the Proxy's role as a caregiver of the

[*PLACE PATIENT LABEL HERE*]

Patient. This information may include a health care directive previously signed by the Patient or other information available to me, together with my determination of the Patient's diminished capacity.

X_____/_____/_____/_____

Physician Signature | Physician Name (printed) | Date | Time

***** Comments on Physician Certification***

There are a variety of circumstances in which another adult would be making decisions for an adult with diminished mental capacity. The physician will need to determine whether is it proper for an adult to be given proxy access to a patient's My CS-Link account if the patient lacks the capacity to provide authorization for the access. The following are observations for guidance.

1. If the patient, at a time when he or she had decision-making capacity, completed a form of legal authorization to make health care decisions for the patient such as an advanced health care directive or health care power of attorney, the agent ("Agent") named in that document may be given proxy access if the patient has lost decision-making capacity. (Be sure to review the document to confirm the authority given).
2. Often the agent is not local and the agent has delegated day-to-day caregiving responsibility to a local care-giver. In such cases, the agent would need to authorize the release of health information to the local caregiver using authorization forms compliant with federal and California law. Forms are available at www.cedars-sinai.edu/medicalrecords. For patients of Cedars-Sinai Medical Group, please visit www.cedars-sinai.edu/medicalgroupnewpatientinfo. Upon receipt of the authorization, the physician should be comfortable giving proxy access.
3. If the physician has an established relationship with the patient, has determined the patient lacks decision-making capacity, and the same caregiver is the clinical decision maker, it may be appropriate for the physician to approve proxy access for that caregiver.
4. If the patient's capacity to make clinical decisions returns, this proxy access should be terminated.

Please feel free to contact Risk Management at 310-423-5935 for questions on the appropriateness of permitting proxy access in any particular situation.

For Official Use:

1. **I have given a photocopy of the signed My CS-Link Authorization document to the Patient.**
2. **I HAVE PLACED A PATIENT LABEL ON EACH OF THE PAGES GOING TO HEALTH INFORMATION.**
3. **I have viewed the Proxy's government-issued ID on** _____ by
   (Date)

_____
(Signature of CSHS Staff) (Printed Name of CSHS Staff)

Patient Name: _____ Patient DOB:_____ Patient MRN (optional):_____

Please return the completed form to the patient's physician's office.

If you have questions about how to fill out the form, please contact the physician's office.