



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 it is 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.**