[*PLACE PATIENT LABEL HERE*]

**Authorization for Third Party Access to My CS-Link Account**
**COMPETENT ADULT**

By completing this form, I am authorizing another adult ("Proxy") access to my My CS-Link Account.

I understand that by authorizing the Proxy to have access to my account, the Proxy will be able to view all information available now or later through My CS-Link. This includes, as examples, test results that may be released before I have reviewed them with my physician, physician notes, medication lists, messages and categories of health information that may not be currently available through My CS-Link. I understand that physician notes, test results and other information in My CS-Link may include sensitive information related to mental health, HIV test results, STD tests, genetic test results, or alcohol and drug abuse.

**Patient Information**

Patient's Name: _____

DOB: _____ Medical Record Number (if known): _____

Phone: _____

Address:_____

City: _____ State: _____ Zip: _____

I authorize the Proxy below to have access to My CS-Link account:

**Proxy Information**

In order to view the Patient's information, the Proxy must also obtain their own My CS-Link account.

Proxy's Name: _____

Proxy's Relationship to the Patient: _____

DOB: _____ Phone: _____

Address:_____

City: _____ State: _____ Zip: _____

**General Acknowledgements**

I understand that:

1. If I refuse to sign this authorization my refusal will not affect my ability to obtain treatment.
2. I may inspect or obtain a copy of the health information to which I am being asked to give the Proxy access.
3. I may revoke this authorization at any time in writing, signed by me or on my behalf and delivered to **Cedars-Sinai Medical Center, Health Information Department, 8700 Beverly Blvd., Room 2901, Los Angeles, CA 90048.**
4. If I revoke this authorization, the revocation will not have any effect on any actions taken prior to receiving the revocation.

[*PLACE PATIENT LABEL HERE*]

5. This authorization will automatically expire as follows: (a) if Patient is not yet 26 years old, the authorization will expire when the Patient turns 26; and (b) if Patient is 26 years old or more, the authorization will expire 10 years from the date signed by Patient.
6. I have a right to receive a copy of this authorization.
7. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

**Authorization and Acknowledgement by Patient:**

**X**_____/_____/_____/_____

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

**Proxy Acknowledgement**

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.

**X**_____/_____/_____/_____

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

**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 bring your completed form to your next visit with your physician.**
**If you have questions about how to fill out the form, please contact your physician's office.**