AUTHORIZATION FOR PROXY ACCESS TO MYCITYOFHOPE – ADULT PATIENT

By completing this form, I am authorizing another adult, also known as "Proxy", to have access to my MyCityofHope Account.

I understand that by authorizing the proxy to have access to my MyCityofHope account, the proxy will be able to view all information available now or later through MyCityofHope. This information may include, for example, clinical diagnoses, clinical procedures, histories of present illnesses, immunizations, allergies, medication information, laboratory test results including test results that may be released before I have reviewed them with my physician, physician notes, information regarding medical research and clinical trials, billing/account and insurance information and categories of information that may not be currently available through MyCityofHope. I understand that this information may also include sensitive information related to mental health screenings, HIV/AIDS, infectious disease, sexually transmitted infection, genetic testing, substance/alcohol use and treatment history, domestic violence, child abuse and family abuse. I also understand that by authorizing a proxy to have access to my MyCityofHope account, the proxy will be able to review and update my account information maintained in MyCityofHope, communicate with my health care providers with regard to my health status, and engage on my behalf, in transactions as permitted by me and my health care providers in MyCityofHope.

Patient Information

FIRST NAME	MIDDLE INITIAL	LAST NAME	DOB
MEDICAL RECORD NUMBER		PHONE NUMBER	EMAIL ADDRESS
ADDRESS	CITY	STATE	ZIP CODE

Would you (patient) like your own MyCityofHope Account?

☐ Active I already have an active MyCityofHope account

☐ Yes If yes, the above email address will be used

☐ No All email notifications of activity in your account will be sent to your proxy's email address

I hereby authorize the following person to have proxy access to my MyCityofHope account:

Patient Authorized Representative ("Proxy") Information

In order to view the patient's information, the proxy must also obtain his/her own MyCityofHope account, but does not need to be a City of Hope patient.

FIRST NAME	MIDDLE INITIAL	LAST NAME	DOB
RELATIONSHIP TO PATIENT		PHONE NUMBER	EMAIL ADDRESS
ADDRESS	CITY	STATE	ZIP CODE

General Acknowledgements

I understand that:

1. Access to treatment or services may not be denied to me if I decline to sign this authorization or revoke my authorization. However, without this authorization, City of Hope will not allow my proxy to access my MyCityofHope account.
2. I may inspect or obtain a copy of my health information at any reasonable time prior to authorizing its disclosure.
3. I may revoke this authorization at any time in writing, signed by me or my personal representative and submit to City of Hope, Health Information Management Services Department, by the delivery methods above. Such revocation will promptly take effect except to the extent that City of Hope already has acted based on this authorization and such refusal or revocation will not affect the commencement, continuation or quality of my treatment at City of Hope.

City of Hope

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How to Submit Form:

Once completed, please forward to the Health Information Management Services Department the following methods below:

Please allow up to 72 hours for processing of your request. Once processed, you will receive a link to activate your MyCityofHope account.

If you have any questions regarding the status of your request, you may follow-up with our Release of Information specialist by contacting the appropriate site below.

COH - California

- **Email:** HIMS-MyCityofHope@coh.org
- **Fax:** (626) 218-8443 Attention: Health Information Management Services (ROI)
- **Mail:** Health Information Management Services (ROI)

City of Hope
1500 East Duarte Road
Duarte, CA 91010

COH - Chicago, Atlanta, Phoenix, Hospitals and Outpatient Care Centers

- **Email:** HIMSROI2@COH.ORG
- **Fax:** (847) 746-6791 Attention: Health Information Management Services (ROI)
- **Mail:** Health Information Management Services (ROI)

City of Hope
2520 Elisha Avenue
Goodyear, AZ 85338

City of Hope

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