DIAGNOSTIC LABORATORY SERVICES, INC.

MyDLSChart
Proxy Request for Authorization

Complete this form to request proxy access of another adult's (18 years and older) MyDLSChart record whose medical care you help manage. The requestor is required to possess an active MyDLSChart account. Without such an active account, the proxy request cannot be granted.

The patient or their legal representative must sign this form to authorize the release of medical information in MyDLSChart Patient Portal. Please note that the patient's chart will be accessed through your (the proxy's) MyDLSChart record.

PSC: User ID:_____
Loc_____
(Fwd to Client Services: Copies of ID, both sides of Birth Certificate, and/or POA with Forms)

Client Services
Date Received:
Request Verified By:
Date Processed/Initials:

When the patient is delegating an adult to proxy, refer to relevant table below to submit the necessary forms and documents. The documents can be submitted in the following ways: Upload to MyDLSChart, email to help@mydlschart.com or mail to Diagnostic Laboratory Services, Inc., Client Services Department, 99-859 Iwaiwa Street, Aiea, HI 96701.

When an ***adult holds a healthcare specific Power of Attorney (POA***) and is requesting proxy for another adult who is 18 years old or older, submit the following documents.
The Requestor 1. Valid Government Issued Photo ID 2. Selfie Image Holding the Same Valid ID
The Patient 3. Valid Government Issued Photo ID
4. Power of Attorney – Healthcare Specific
5. Completed FORM 1-AA (two pages)

When an ***adult without POA*** is requesting proxy for another adult who is 18 years old or older, submit the following documents.
The Requestor 1. Valid Government Issued Photo ID 2. Selfie Image Holding the Same Valid ID
The Patient 3. Valid Government Issued Photo ID 4. Selfie Image Holding the Same Valid ID
5. Completed FORM 1-AA (two pages)
6. Completed FORM 2-AA (one page)

Requestor's Information: All sections must be completed – incomplete forms will not be processed.

This section must be completed by the proxy individual requesting access to another patient's MyDLSChart record. We will contact the patient to verify the request before approving proxy access. Please note that this verification process may take up to 30 days.

Name *(Last, First, M.I.)*: _____

Date of Birth: _____ **Last 4 digits of SSN:** _____ **Phone:** _____

Email: _____

Address: _____

_____

Primary Clinic/Provider *(not required but recommended)*: _____

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Patient's Information: All sections must be completed – incomplete forms will not be processed.

This section must be completed by the patient who is authorizing proxy access to their medical record via the MyDLSChart Patient Portal. To ensure that a proxy action is requested, you will be contacted to confirm the proxy information.

Name *(Last, First, M.I.)*: _____

Date of Birth: _____ **Last 4 digits of SSN:** _____ **Phone:** _____

Email: _____

Address: _____

_____

Primary Clinic/Provider *(not required but recommended)*: _____

MyDLSChart Agreement

I understand that:

- MyDLSChart is intended as a secure online source of confidential medical information.
- MyDLSChart is not to be used in an emergency.
- The use of MyDLSChart is voluntary and I am not required to use MyDLSChart or to authorize a MyDLSChart proxy.
- It is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way. If I share my MyDLSChart ID and password with another person, that person may be able to view my or my child's health information, as well as information about any individual who has authorized me as a MyDLSChart proxy.
- If I am authorized for proxy access to another person's record, I must log in to my own MyDLSChart account and click on "View Other Records" to access their record online.
- MyDLSChart contains selected, limited medical information from a patient's medical record and that MyDLSChart does not reflect the complete contents of the medical record.
- Access to MyDLSChart is provided by Diagnostic Laboratory Services, Inc. (DLS) as a convenience to its patients and that DLS has the right to deactivate access to MyDLSChart at any time for any reason.

By signing below, I agree to abide by the terms and conditions on the MyDLSChart site. Terms and Conditions are viewable within MyDLSChart.

_____ /_____ /_____

Your (Proxy) Signature **Relationship to Patient** **Date**

Patient Acknowledgement: I acknowledge that I have read and understand this MyDLSChart Adult Proxy Registration Form. I agree to its terms and choose to designate the person named above as my MyDLSChart Proxy, thereby allowing them access to my MyDLSChart record.

_____ /_____ /_____

Patient (or Legal Representative) Signature **Relationship to Patient** **Date**

NOTE: Authorization expires one year from the date of signature. A new MyDLSChart Proxy Authorization Form must be submitted each year to renew proxy access. You can deactivate the access of the adult proxy specified above at any time by providing a written request to DLS Client Services.