DIAGNOSTIC LABORATORY SERVICES, INC.

MyDLSChart
Authorization of Proxy Request

This form is an authorization that will permit providers utilizing Diagnostic Laboratory Services, Inc. (DLS) Electronic Health Record (EHR) system to release your medical information in your MyDLSChart to your designated adult proxy. Please read it carefully.

This form should be completed by the patient who is authorizing another adult proxy access to their medical information via the MyDLSChart Patient Portal. To obtain a Form 1-AA, please go to your nearest DLS satellite location, or access the form online at www.MyDLSChart.com.

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:

Patient Full Name (Last, First, M.I.): _____

Last 4 digits of SSN: _____ Date of Birth (mm/dd/yyyy): _____

I authorize _____ (insert name of proxy) access to my health information that is available in my MyDLSChart account. This person is my designated MyDLSChart proxy. I understand that the medical information in MyDLSChart is obtained from my electronic medical record and may include information from all laboratory services from DLS.

I authorize release of all health information contained in my MyDLSChart to my designated proxy; including any of the following information should it be contained in my MyDLSChart: Acquired Immune Deficiency Syndrome and ARC or HIV, alcohol and/or drug abuse treatment and/or behavioral services. I understand that this authorization applies only to the release of the information through my MyDLSChart. This form does not authorize release of my medical record to my designated proxy by other methods or in other forms.

I understand that once the information has been disclosed to my proxy through MyDLSChart, it may be re-disclosed by the proxy and no longer protected by federal privacy regulations.

Participation in MyDLSChart and designating a MyDLSChart proxy is completely voluntary. I understand that I am not required to designate a MyDLSChart proxy, and I am not required to provide this authorization. I also understand that DLS and my providers will not condition any of my health care treatment, payment, enrollment, or eligibility for benefits on whether I provide this authorization.

This authorization will automatically expire one year from the date of my signature. I understand that I may revoke this authorization at any time by providing a written request for revocation to DLS Client Services at Diagnostic Laboratory Services, Inc. (99-859 Iwaiwa Street Aiea, HI 96701). I understand that if I revoke this authorization, my designated proxy's access to my MyDLSChart record will be ended within five (5) business days of receipt of the revocation request. I also understand my revocation will not apply to any information that was already disclosed in reliance on this authorization.

_____ _____
Signature of Patient (or Personal Representative) Date of Signature

_____
Printed name of signee

If person other than the patient signs, indicate authority to sign for patient (e.g., guardian) and attach documentation as applicable:_____