PROXY CONSENT FORM

Ophthalmology LIMITED

The purpose of this form is to authorize someone else to access your electronic record. If you want someone else to have access to your records, this person is called your Proxy, and you need to fill out this form. This form may be completed at any of our clinics or our surgery center when you are able to sign in the presence of an employee. If you're unable to complete the form in one of our offices, a notarized copy of this completed form may also be mailed to us. A notary is a person with a special license to witness your signature. A notarized form can be mailed to: Ophthalmology Ltd., 6601 S. Minnesota Avenue, Suite #200, Sioux Falls, SD 57108.

About the Patient/Member: (All sections required-please print clearly)

Name (last, first, middle initial)_____ Date of Birth _____

Last 4 digits of Social Security Number: _____ Email: _____

Phone Number: _____ Member ID Number (if applicable): _____

About the Proxy: (All sections required - please print clearly.)
Complete for the person getting access to the Patient/Member's record.

Name (last, first, middle initial)_____ Date of Birth _____

Last 4 digits of Social Security Number: _____ Email: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Member ID Number (if applicable): _____

In signing this form, you agree and understand the following:

I ask that my Proxy (whose name is above) have access to my complete medical and/or health insurance record and any medical record sharing platforms linked to my record. I understand the data may include medical, billing and insurance information. I also give consent for my Proxy to do these things for me:

- See and send messages to my healthcare team or insurance.
- Update my name, other personal data, and payment or insurance details.
- See who has accessed my medical or health insurance record through my record.
- Get copies of any part of my medical or health insurance record.

I understand and agree:

- My Proxy may have access to behavioral health and alcohol or drug treatment records and/or claims.
- Records given to my Proxy may be given to others and no longer protected.
- My Proxy may have access to medical records incorporated into this record through my use of linked medical record sharing platforms, exchanges, and third-party applications.

Naming a Proxy is my choice and not required. I do not have to give this consent. I will receive care even if I do not sign this consent. I understand that if I do not sign this, access will not be given to my Proxy. If I am over 18, this consent expires 5 years from the date of my signing. If I am a minor, it will expire when I turn 18.

I may take away consent through myPatientPortal or by mail to the address above. I understand that if I take away consent, my Proxy's access to my health record will end. I understand this will not prevent the release of data already given.
I have read and understand this form.

_____/_____/_____

Signature of Patient (or authorized person) (Required) **Relationship to Patient** **Date/Time**