Consent Form for Proxy Access to myNYP.org

(For record-keeping purposes only; HIPAA-compliant authorization not required)

Complete this form to grant an individual myNYP.org proxy access to the patient's myNYP.org account. See myNYP.org Terms and Conditions for details. This applies to all associated inpatient and outpatient institutions.

Patient Information

Patient Name: ____ DOB: _______________

Street: ____

City: ______________________ ST: ____ Zip: _____________

Phone (to best contact patient directly): ___________________

Email Address: _______________________________________

Proxy Information

(The individual specified below, age 18 or older, will be granted access to the account of the patient specified above)

Proxy Name: ____ DOB: _______________

Relationship to patient: _______________________________

Email Address: ______________________________________

[_] - Check if address same as that of patient listed above

Street: ____

City: ______________________ ST: ____ Zip: _____________ Phone: _______________

Grant Proxy Access

By signing below, all parties confirm that they agree to the myNYP.org Terms and Conditions.
[Note: all three signatures are needed.]

________________________ ___________________________ ____/_____/___ Time:________AM/PM
Patient Signature | Printed Name | Date: mo/day/year

________________________ ___________________________ ____/_____/___ Time:________AM/PM
Proxy Signature (must be 18 years of age or older) | Printed Name | Date: mo/day/year

________________________ ___________________________ ____/_____/___ Time:________AM/PM
Physician or Advanced Practitioner Signature | Printed Name | Date: mo/day/year

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*Staff: Scan this completed form onto the patient's chart under Advanced Directive category **and** notify myNYP support team upon completion at myNYP@nyp.org. They will send the proxy the email invitation to connect to the patient's medical information.
**IF this form is being delivered to a Health Information Management drop-off location or mailed to them, please include a cover letter indicating that this form needs to be scanned onto the patient's chart. Thank you.