Vanderbilt University Medical Center

Caregiver Access to the My Health at Vanderbilt (MHAV) Account of a Diminished Capacity Patient over 18 Years Old

MHAV Access – Diminished Capacity Adult

Patient Label or Patient Identifiers

Patient Name: _____

Patient Date of Birth: _____/_____/_____ Last 4 digits of the Patient's Social Security Number: _____

Access for a Caregiver/Legal Representative to the My Health at Vanderbilt (MHAV) Account of a Diminished Adult 18 and Older

Email Address of Caregiver: _____

You must provide an email address. Notice of MHAV messages in your account will be sent only to this email address. **Previous email addresses will be deleted.**

Caregiver's Name: _____

Address: _____

Caregiver's Date of Birth: _____ Phone Number: _____

Last 4 digits of Caregiver's Social Security#: _____

Are you currently or have you ever been a patient at Vanderbilt? ☐ Yes ☐ No

Former Name(s), such as maiden name: _____

Relation to patient: ☐ Parent ☐ Legal Representative

Primary access to a diminished capacity adult's account is only available to individuals with documented status as a legal representative.

I am the legal representative of the adult named above and I request access to the adult's information online through MHAV. I understand the requirements and procedures for accessing the adult's information online through MHAV. I understand the adult will also have access to their own MHAV account. All the information I have provided is correct, and I have rights to access the adult's information online through MHAV.

Caregiver's Print Name: _____

Caregiver's Signature: _____

Relation: _____ **Date:** _____ **Time:** _____

This form can also be used to grant access for a caregiver or legal representative of an adult who has a medical condition determined by the adult's provider that prevents the adult from participating in making MHAV access decisions. The provider signs below to signify such a condition exists for this patient.

FOR CLINIC USE ONLY:
Parent's/Legal Representative's & Patient's ID verified by VUMC Staff or Provider:

Print Name: _____ Title: _____

Signature: _____ Date: _____ Time: _____

Fax to (615) 875-2820.
Or, if you have access to campus mail, send to HealthIT, My Health at Vanderbilt, 3401 West End Suite 500 E, Nashville, TN 37203 Campus Zip 8363

Provider Print Name: _____ Title: _____

Provider Signature: _____ Date: _____ Time: _____