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 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

Caregiver's Email Address: _____

*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: _____

City: _____ State: _____ Zip Code: _____

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 or other names: _____

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.

**Please provide legal documentation to the clinic or fax to 615-875-2820. This includes: Power of Attorney, Conservatorship, , etc. You may also submit documentation via secure email to MHAVLegal@vumc.org. Please note that email that is not sent securely (i.e., unencrypted email) may be intercepted and seen by others during transmission. By choosing to send information by unencrypted email, you accept these risks.*

Caregiver's Print Name: _____

Caregiver's Signature: _____

Relation to patient: _____ **Date:** _____ **Time:** _____

Provider Agreement

This form is 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.

Provider Print Name: _____ Title: _____

Provider Signature: _____ Date: _____ Time: _____

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

Print Full Name: _____ Title: _____

Full Signature: _____ Date: _____ Time: _____

Vanderbilt staff, please fax to (615) 875-2820.