# 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: _____

### Caregiver or Legal Representative's Agreement

**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: _____

** An application and legal documentation are required to obtain My Health at Vanderbilt Access. Legal documents include but are not limited to Powers of Attorney that include health care decisions, Conservatorship, Guardianship, etc. If you are unable to provide legal documents at the clinic, please submit legal documents **ONLY** via fax (615-875-2820) or secure email (MHAVLegal@vumc.org). **Applications can only be submitted by a VUMC staff member and will not be accepted via by fax or secure email**. Please note that emails not sent securely (i.e., unencrypted email) may be intercepted and seen by others. When you choose this option, you assume these risks. **

**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 the right to access the adult's information online through MHAV.

**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.



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