Wake Forest®
Baptist Health

Request for Proxy Access to MyWakeHealth for Individual with Diminished Mental Capacity

Required information about the patient:

Last Name: _____ First Name: _____ Middle Name: _____

(As appropriate) Maiden Name: _____

Date of Birth (mm/dd/yyyy): _____

Last 4 digits of social security number:_____ OR WFBMC Medical Record number: _____

Street Address: _____

City: _____

State: _____ Zip: _____

Required information about the proxy:

Last Name: _____ First Name:_____ Middle Name: _____

(As appropriate) Maiden Name: _____

Date of Birth (mm/dd/yyyy): _____

Last 4 digits of social security number:_____ OR WFBMC Medical Record number: _____

Street Address: _____

City: _____

State: _____ Zip: _____

Phone number with area code: (____)_____

Email address: _____

Required documentation:

Provide either:

A copy of the court order appointing guardian and Letters of Guardianship verifying the requester's status as permanent legal guardian of the patient.

--OR--

Durable Power of Attorney for Healthcare and physician certification verifying the patient lacks decisional capacity.

--OR--

For patients 17 years and under: provider certification that the patient lacks decisional capacity is present in Wake One AND parent or legal guardian completion of this document

Expiration:

This authorization does not expire for a patient who is 18 years of age or older unless physician certification is provided indicating that the patient has regained decisional capacity. For a patient who is 17 years of age or younger, this form will expire when the patient turns 18 years of age.

Proxy Signature: _____

Date: _____

Chart Copy

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