MyChart® Adult Proxy Form

Access to Another Adult's *MyChart*® Record

To request access to the MyChart® record of an adult whose medical care you help manage, please complete this form. This form must be accompanied by the Adult Proxy Authorization for Release of Medical Information Form signed by the patient. Access will only be granted upon receipt of both signed documents. Please note that the patient's chart will be accessed through your (the proxy's) MyChart® account. If you do not currently have a MyChart® account and sign up during your office visit the staff will assist you in obtaining your login and password information.
Return completed forms to the patient's physician's office.

Your (Proxy) Information (All sections required – please print clearly.)

This section needs be completed by the individual requesting access to another adult's MyChart® record.

Name (*last, first, middle initial*) _____ Date of Birth _____

Social Security Number: _____ Email: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Relationship to Patient _____

Reason for request: _____

Patient's Information (All sections

Complete this section with information about the patient whose MyChart® record you're requesting to access.

Name (*last, first, middle initial*) _____ Date of Birth _____

Social Security Number: _____ Email: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Primary Physician: _____

MyChart® Terms and Agreement

- I understand that MyChart® is intended as a secure online source of confidential medical information. If I share my MyChart® ID and password with another person, that person may be able to view my health information and the health information about someone who has authorized me as a MyChart® proxy.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.
- I understand that MyChart® contains selected, limited medical information from the patient's medical record and that MyChart® does not reflect the complete contents of the medical record. I understand that authorization of the patient for MyChart® Proxy Access does not entitle me to access the patient's entire medical record. Requests for medical records are processed in accordance with Federal and State laws, and MERCY HEALTH Policies and Procedures.
- I understand that my activities within MyChart® may be tracked by computer audit and that entries I make may become part of the patient's medical record.
- I understand that the medical providers who are responsible for the patient's care may rely upon information provided in MyChart®. **I understand that I must provide complete and accurate information.** I further understand that I am solely responsible for any action taken by care providers in reliance upon any entries I make in MyChart® and/or the medical record.
- I understand that access to MyChart® is provided by MERCY HEALTH as a convenience to its patients and that MERCY HEALTH has the right to deactivate access to MyChart® at any time for any reason.
- **I understand that** MyChart® **is not to be used in an emergency.**

By signing below, I acknowledge that I have read and understand this MyChart® Adult Proxy Sign-up form. I understand that this request must be accompanied by valid MyChart® **Adult Proxy Authorization for Release of Medical Information s**igned by the patient, and that access will not be granted until this documentation is on file. I understand that the patient has the right to revoke my Proxy access at any time. I agree to the terms and conditions of MyChart® use and Proxy Access, and agree to only use this access for the sole purpose of assisting in the medical management of the patient in accordance with the patient's authorization and requests. MyChart®.

/ /

Signature of Proxy (*Required)* **Relationship to Patient** **Date**

REQUESTS FOR PROXY ACCESS WILL ONLY BE CONSIDERED WHEN ACCOMPANIED BY A COMPLETED AND SIGNED *MYCHART® ADULT POXY AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FORM* SIGNED BY THE PATIENT.

PROXY ACCESS IS VALID FOR ONE YEAR UNLESS CANCELLED BY THE PATIENT PRIOR TO EXPIRATION OF THE AUTHORIZATION.

MERCYHEALTH

MyChart® Adult Proxy
Authorization for Release of Medical Information

This form is an authorization that will permit MERCY HEALTH to release your medical information to your designated adult proxy. Please read it carefully.

This form is to be completed by the patient who is authorizing another adult to access medical information in his or her MyChart® record. It must accompany the MyChart® Adult Proxy Form, which provides the name and information of the individual who you are authorizing to access your MyChart® record as a proxy.

Patient Name (*last, first, middle initial*) _____

Social Security Number: _____ Date of Birth: _____

I _____ ***(print name of patient)*** am requesting that _____ _____ ***(print name of proxy)*** receive access to my health information that is available in my MERCY HEALTH MyChart® Record. This person is my designated MyChart® proxy. I authorize MERCY HEALTH to release the health information contained in my MyChart® record to my MyChart® proxy. I understand that the medical information in MyChart® is obtained from my electronic medical record and may include information from all facilities listed in MERCY HEALTH Notice of Privacy Practices. I authorize release of any information contained in my MyChart® held by MERCY HEALTH to my designated proxy.

Participation in MyChart® and designating a MyChart® proxy is completely voluntary. I understand that I am not required to designate a MyChart® proxy and I am not required to provide this authorization. I also understand that MERCY HEALTH does not condition any of my health care treatment, payment or other services on whether I provide this authorization. I also understand that if I do not provide authorization, MERCY HEALTH is not permitted to provide access to my MyChart® record to my designated proxy.

I understand that access to MyChart® is provided by MERCY HEALTH as a convenience to its patients and that MERCY HEALTH has the right to deactivate access to MyChart® at any time for any reason.

I understand that MyChart® is intended as a secure online source of confidential medical information. I further understand that if MyChart® IDs and passwords of either the patient or the Proxy are shared with another person, that person may be able to view my health information and information. I understand that once information has been disclosed, it potentially may be re-disclosed. Disclosed information may not be covered by federal privacy protections. I understand that MERCY HEALTH assumes no liability for information released by the patient, the proxy or other third parties.

I understand that my activities and those of my Proxy within MyChart® may be tracked by computer audit and that entries made by me or my Proxy may become part of the medical record. I understand this information and agree to grant access to my Proxy. By granting this access I understand that I am relying upon my Proxy to enter complete and accurate information into my MyChart® and that my care providers may rely upon information entered into MyChart® by my Proxy. I further understand that MERCY HEALTH assumes no liability for incorrect information entered by me or my Proxy and relied upon by my care providers.

I authorize release of my medical information to my Proxy only through my MyChart® record. This form does not authorize release of my medical record or other medical information outside of MyChart® to my designated proxy by other methods or in other forms.

MERCYHEALTH

This authorization will **expire automatically one year from the date of my signature**. In order for my Proxy to continue to have access I will need to sign a new authorization form.

I understand that I may revoke this authorization at any time by providing a written request for revocation to my primary physician's office. I understand that if I revoke this authorization, my designated proxy's access to my MyChart® record will be terminated, and that this termination process may take up to 3 business days from receipt of the written request to terminate proxy access. I also understand my revocation will not affect any disclosures that were made prior to processing the revocation request.

By signing below I acknowledge that I have read and understand the information contained in this document. I have had the opportunity to discuss this authorization with a representative of my physician's practice, and I have had any questions answered to my satisfaction.

Primary Facility or Physician:_____

Signature of Patient: _____Date: _____

If person other than the patient signs, indicate authority to sign for patient (e.g., guardian) and attach documentation: _____

Authorization expires one year from the date of signature (above).
A new MyChart® *Proxy Authorization Form* must be submitted each year to renew proxy access.
You may deactivate adult proxy access at any time by providing a written request to your primary physician's office.