

## MyChart Adult Proxy Form

### Access to an Adult's MyChart Record

To request access to the MyChart record of an adult whose medical care you help manage, please complete this form. The patient's MyChart record will be accessed through your MyChart record. If you do not have access to MyChart an activation letter will be sent to your home address. You will then need to activate your account in order to view the MyChart record as a proxy.

### To The Proxy/Agent\*

### MyChart Terms and Agreement

- I understand that MyChart is intended as a secure online source of confidential medical information.
- I understand that it is my responsibility to select a confidential password.
- I understand that MyChart contains selected, limited medical information from the medical record and that MyChart does not reflect the complete contents of the medical record. I also understand that a complete copy of my medical record may be requested from the provider of care.
- I understand that my activities within MyChart may be tracked by computer audit and that entries I make may become part of the medical record.
- I understand that access to MyChart is provided by University Hospital and Subscribing Providers as a convenience to its patients and that University Hospital and Subscribing Providers have the right to deactivate access to MyChart at any time for any reason.
- I understand that use of MyChart is a voluntary, optional service and that patients are not required to use MyChart.

### Patient's Information (All sections required – please print clearly)

Complete this section with information about the patient for whose MyChart record you are requesting/granting access:

First, Middle Initial, Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

SSN# \_\_\_\_\_ Email \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone Number: \_\_\_\_\_

### To The Person Granting Access

#### Patient hereby agrees to the following:

- I authorize release of any information (including any protected health information) contained in my MyChart medical record maintained by University Hospital and Subscribing Providers to the person named below as my MyChart proxy.
- I understand that MyChart contains selected, limited medical information from a patient's medical record and that MyChart does not reflect the complete contents of the medical record. MyChart may include medical information relating to diagnosis of mental illness, alcohol/drug abuse, sexually transmitted diseases, HIV, some communicable diseases, prevention of pregnancy, pregnancy and childbirth. MyChart does not include physician notes. MyChart may include prescription medications and reasons for provider visits, past and future. I understand that it is not technically possible at this time to grant MyChart access that would not include these categories of information.
- This release is valid for information **only** through the MyChart record. This form does not authorize release of my medical record to my designated proxy by other methods or in other forms.
- I understand that once information has been disclosed, it potentially may be re-disclosed by the proxy and the disclosed information may not be covered by federal privacy protections. I acknowledge that University Hospital and the Subscribing Providers have no responsibility for any such re-disclosure.
- I may revoke this authorization at any time online pursuant to instructions at [www.uhmychart.org](http://www.uhmychart.org) or by providing a written request for revocation to the MyChart Administrator. I understand that if I revoke this authorization, my designated proxy's access to MyChart will be ended. I also understand my revocation will not affect any disclosures that were made prior to processing this revocation request.
- By signing below, I acknowledge that I have read and understand this MyChart Adult Proxy Form and the terms and conditions on the MyChart website at [www.uhmychart.org](http://www.uhmychart.org) and agree to its terms.
- I understand that this authorization is voluntary. I am confirming my authorization that the health care provider may communicate and disclose to the person named in this form the protected health information displayed in MyChart.

\_\_\_\_\_  
Signature of Patient or Authorized Person\*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of person given access to information using MyChart (proxy)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
SSN #

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Signature of Proxy Being Given Access

Your Relationship To Patient Listed Above: \_\_\_\_\_

- Reference to "I" or "my" are "patient" perspective if executed by an agent or guardian, who is also bound by the terms. This shall mean an agent under a power of attorney granting the authority to consent to disclosures of protected health information; Parent or Guardian of a minor; or Court Appointed Guardian. \*\* Copy of the appropriate legal document is required.

**Fax completed form to the Health Information Department at 706-774-8631. You will be sent your MyChart activation code by email or mail.**

**NOTE: If received with incomplete or illegible information, it cannot be processed. One attempt to contact you by phone will be made.**

Revised 09/08/2016