

# MyChart: Authorization for Proxy Access to Adult Patient Account Ages 18+

To request access to the MyChart record of an adult patient whose medical care you help manage, please complete this form. A "Proxy" may be a patient's parent, legal guardian or Power of Attorney. The Proxy will be able to access portions of the health record, such as Immunizations, Problem List, Medications, Allergies, History, and messages with the patient's providers.

State and Federal laws require the consent of the patient before the release of certain types of medical information to a parent, guardian or proxy. This type of information may be very sensitive or private. Because of these legal requirements, both the patient and the Proxy must sign this Authorization form. Proxy Access expires when the patient revokes (takes back permission).

## Patient Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.

## Proxy Information:

Check Box: \_\_\_\_\_ Parent \_\_\_\_\_ Legal Guardian\*\* \_\_\_\_\_ Power of Attorney\*\*

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

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\*\*A copy of the legal paperwork verifying the authority of the patient's personal representative (e.g., court appointed guardian documents, durable power of attorney for health care) must be accompany this form.

\_\_\_\_\_  
Patient Signature (Ages 18+)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Proxy Signature

\_\_\_\_\_  
Date