MyChart Adult Proxy Form

You must complete this form and the attached HIPAA Authorization to request that someone else involved in your care have access to your Phelps Health *MyChart* account. This person is called your "Proxy."

Please note that your Proxy will access your information through his/her own *MyChart* account. If your Proxy does not have a *MyChart* account, upon approval of this request, he/she will receive a *MyChart* activation code along with instructions on how to sign up for *MyChart* and create a *MyChart* account.

PATIENT INFORMATION - (YOU) (ALL SECTIONS REQUIRED – PLEASE PRINT CLEARLY):

Name: ____________________

Date of Birth: ____________________ SSN: ____________________

Street Address: ____________________ City: ____________ State: ________ Zip: ________

Email: ____________________ Phone Number: ____________________

PROXY INFORMATION - (YOUR PROXY) (ALL SECTIONS REQUIRED – PLEASE PRINT CLEARLY):

Name: ____________________

Date of Birth: ____________________ SSN: ____________________

Street Address: ____________________ City: ____________ State: ________ Zip: ________

Email: ____________________ Phone Number: ____________________

Relationship to Patient: ☐ Spouse ☐ Relative ☐ Primary caregiver ☐ Other ____________

I understand that:

- Use of *MyChart* is voluntary and I am not required to use *MyChart* or grant access to a Proxy. If I grant access to a Proxy, he/she will have access to my *MyChart* medical records.
- I may revoke access to a Proxy at any time by sending written notification to Phelps Health HIM department, 1000 West 10th Street, Rolla, MO 65401.
- *MyChart* is intended as a secure online portal for viewing confidential medical information. It is my responsibility to select a confidential password, to maintain my password in a secure manner (*i.e.*, not share it with anyone), and to immediately change my password if I believe it may have been compromised. I also understand that if I share my username and password with another person, then that person may be able to view my medical information.
- *MyChart* contains selected, limited medical information from my medical record and does not reflect the complete contents of my medical record. I also understand that this form addresses access only through *MyChart* and does not address access to medical records by other methods or in other formats.
- *MyChart* is provided by Phelps Health as a convenience and Phelps Health has the right to deactivate access to *MyChart* at any time for any reason.
- "Phelps Health" refers to Phelps Health and its affiliates Phelps Health Medical Group and Phelps Health Homecare.
- This request will expire in one year if my Proxy does not activate a *MyChart* account in that time.

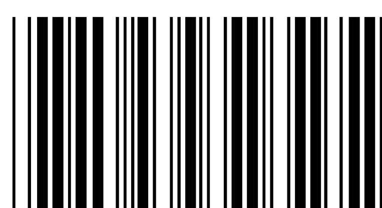
By signing below, I acknowledge that I have read and understand this *MyChart* Adult Proxy Form. I agree to its terms and choose to designate the person named above as my *MyChart* Proxy, thereby allowing him/her access to my *MyChart* medical record.

Signature of Patient: ____________________ Date: ____________ Time: ____________

By signing below, I acknowledge that I have read and understand this *MyChart* Adult Proxy Form and I agree to its terms.

Signature of Proxy: ____________________ Date: ____________ Time: ____________

Release of Information: MyChart



MyChart Adult Proxy HIPAA Authorization

Patient Name: ______________________________ Date of Birth: ______________________

I am requesting that ______________________________ (name of patient's *MyChart* Proxy) have access to my Phelps Health *MyChart* account. This person is my designated *MyChart* Proxy.

I hereby authorize Phelps Health to release my health information available in my Phelps Health *MyChart* account to my Proxy. The health information released includes all information that is available in my Phelps Health *MyChart* account, which may include information about drug/alcohol abuse, mental health treatment, sexually transmitted diseases, HIV/AIDS testing/treatment, or any other sensitive information.

The form authorizes access only through *MyChart* and does not authorize release of my health information to my Proxy by other methods or in other formats.

I understand that:

- Signing this authorization is voluntary.
- Phelps Health does not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
- I may revoke this authorization at any time by sending written notification to Phelps Health HIM department, 1000 West 10th Street, Rolla, MO 65401, but if I do, it will not have any effect to the extent that action has already been taken based on this authorization.
- My health information may be subject to re-disclosure by my Proxy and will no longer be protected by federal or state privacy laws.
- This authorization will expire one year from the date of my signature below.
- "Phelps Health" refers to Phelps Health and its affiliates Phelps Health Medical Group and Phelps Health Homecare.
- I have the right to receive a copy of this authorization.

By signing this authorization, I hereby authorize Phelps Health to disclose my protected health information as specified in this authorization.

Signature of Patient or Personal Representative: ______________________________

Date: ______________ Time: ______________

Name of Patient or Personal Representative: ______________________________

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Description of Personal Representative's Authority to Sign for Patient (Attach documents that show authority)

Release of Information: MyChart