



## 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. If physically and/or cognitively able to do so, the patient must sign this form and provide authorization for release of medical information in MyChart on the "Adult Proxy Authorization Form." Please note that the patient's chart will be accessed through your (the Proxy's) MyChart record. Completing this form will establish a MyChart record for you and for the patient.

### Your/Proxy's Information (All sections required – please print clearly)

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

Name (last, first, middle initial): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number (last 4 digits only): \_\_\_\_\_ Email: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

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

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 (last 4 digits only): \_\_\_\_\_ Email: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## 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/or health information about someone who has authorized me as a MyChart proxy (e.g., the Patient).
- 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 also understand that a paper copy of the Patient's medical record may be requested from Shepherd Center.
- 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 access to MyChart is provided by Shepherd Center as a convenience to its patients and that Shepherd Center has the right to deactivate access to MyChart at any time for any reason. I understand that use of MyChart is voluntary and I am not required to use MyChart or to authorize a MyChart proxy.
- By signing below, I acknowledge that I have read and understand this MyChart Sign-Up Form and I agree to its terms.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

<b>Your (Proxy) Signature (Required)</b>	<b>Relationship to Patient</b>	<b>Date</b>
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I acknowledge that I have read and understand this MyChart Sign-up form. I agree to its terms and choose to designate the person named above as my MyChart Proxy, thereby allowing them access to my MyChart medical record.

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<b>Signature of Patient (or authorized person) (Required)</b>	<b>Relationship to Patient</b>	<b>Date</b>
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# Adult Proxy Authorization for Release of Medical Information

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

**If the patient is otherwise physically and/or cognitively able to do so, this form should be completed by the patient who is authorizing another adult to access medical information in his or her MyChart record. It must accompany the Adult Proxy Form, which provides the name and information of the individual who the patient is authorizing to access their MyChart record as a proxy. If you do not have an Adult Proxy Form, please contact Shepherd Center.**

Patient Name (*last, first, middle initial*): \_\_\_\_\_

Social Security Number (last 4 digits only): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I am requesting that \_\_\_\_\_ (*insert name of proxy*) receive access to my health information that is available in my Shepherd Center MyChart Record. This person is my designated MyChart proxy. I authorize Shepherd Center 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. I authorize release of any information contained in my MyChart medical record held by Shepherd Center to my designated proxy.

I authorize release of this information only through my 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 and/or State privacy protections.

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 Shepherd Center does not condition any of my health care treatment, payment or other services on whether I provide this authorization. However, I also understand that if I do not provide authorization, Shepherd Center is not permitted to provide access to my MyChart record to my designated proxy.

I may revoke this authorization at any time by providing a written request for revocation to Shepherd Center. I understand that if I revoke this authorization, my designated proxy's access to my MyChart record will end. I also understand my revocation will not affect any disclosures that were made prior to processing the revocation request.

Date: \_\_\_\_\_

Signature of Patient (or authorized person): \_\_\_\_\_

Printed Name: \_\_\_\_\_

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

\_\_\_\_\_