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. 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

Return all forms to: Muskingum Valley Health Centers
C/o Information Technologies
716 Adair Ave.
Zanesville, OH 43701

Your 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: _____ Email: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ Physician: _____

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

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

Name (*last, first, middle initial*) _____ Date of Birth: _____
Social Security Number: _____ Email: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ 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 or my child's health information, and 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 a 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 a patient's medical record may be requested from the physician's office.
- 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 Genesis HealthCare System and my physician office/organization as a convenience provides access to MyChart to its patients and that Genesis HealthCare System and my physician office/organization have 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 Adult Proxy Form and I agree to its terms.

▶ _____

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

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 them access to my MyChart medical record.

▶ _____

Signature of Patient/Authorized Person *(Required)* **Relationship to Patient** *(Required)* **Date** *(Required)*

NOTICE REGARDING DRUG/ALCOHOL AND MENTAL HEALTH

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTECTED BY FEDERAL CONFIDENTIALITY RULES (42 CFR, PART 2). THE FEDERAL RULES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN AUTHORIZATION OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR, PART 2. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. THE FEDERAL RULES RESTRICT ANY USE OF THE INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE PATIENT. YOUR PHYSICIAN MAY DETERMINE MENTAL HEALTH/PSYCHIATRIC OR ANY SENSITIVE DIAGNOSIS MAY NOT BE VIEWED ELECTRONICALLY.

▶ ***Please remember to complete page 2 of this form.***

MyChart

Adult Proxy Authorization for Release of Medical Information

This form is an authorization that will permit my physician's office to release your medical information to your designated adult proxy. Please read it carefully.

The patient who is authorizing another adult to access medical information in his or her MyChart record should complete this form. 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.

Patient Name (*last, first, middle initial*) _____
Social Security Number: _____ **Date of Birth:** _____

I am requesting that _____ *(insert name of proxy)* receive access to my health information that is available in my physician's office MyChart Record. This person is my designated MyChart proxy. I authorize my physician 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 my physician's office Notice of Privacy Practices. I authorize release of any information contained in my MyChart medical record held by my physician's office 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 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 my physician's office 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, my physician's office is not permitted to provide access to my MyChart record to my designated proxy. I understand that I am not required to sign this authorization form and my physician will not condition the provision of treatment or payment based on signing of this authorization.

This authorization will expire automatically one year from the date of my signature. I also may revoke this authorization at any time by providing a written request for revocation to my primary clinic. I understand that if I revoke this authorization, my designated proxy's access to my MyChart record will be ended. I also understand my revocation will not affect any disclosures that were made prior to processing the revocation request.

Date: _____ **Physician:** _____

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:
_____

NOTE: **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 also may deactivate the access of the adult proxy specified above at any time through MyChart or by providing a written request to your physician's office.**

For Office Use Only:
Information Release Date: _____ Physician Name: _____
Name of staff member/department: _____

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