MyChart – Access Authorization with Adult Proxy

Patient Information
All fields are required.

Patient Name: _____ DOB: _____

Address: _____ Email address: _____

City, State, Zip: _____ Phone Number: _____

Proxy Information
All fields are required.

Proxy Name: _____ DOB: _____

Address: _____ E-mail address: _____

City, State, Zip: _____ Phone Number: _____

Relationship to Patient: _____

MyChart Terms and Conditions:

I understand the following:

- MyChart contains selected, limited medical information from a patient's medical record and does not reflect the complete contents of the medical record. A paper copy of a patient's medical record may be requested from the patient's health care provider.
- My activities within MyChart are tracked by computer audit, and entries I make can become part of my medical record or the above-named patient's medical record.
- I understand that my access to any information about the patient may be revoked by the patient through a written request.
- I agree to abide by the ACP MyChart Terms and Conditions, which are available at _____

By signing below, I acknowledge that I am providing documentation of my authorization to access the protected health information of the patient described above. I certify that I am legally authorized to access such information about the patient named above, and that the information I have provided is true and correct.

Proxy Signature: _____ **Date:** _____

I acknowledge that I have read and understand this MyChart adult proxy form. I agree to its terms and designate the person named above as my MyChart proxy, thereby allowing him/her access to my MyChart medical record.

Patient Signature: _____ **Date:** _____

For Office Use Only

Patient MRN:	Proxy Activation Date: