The Christ Hospital

MYCHART
ADULT PROXY ACCESS REQUEST FORM

Completing this form allows someone else ("Proxy") to be able to access portions of the Patient's protected health information maintained by The Christ Hospital and/or any of their affiliates through MyChart. The Patient and Proxy must agree to and comply with the terms and conditions on the MyChart web page, and this document.

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

E-mail Address: ______________________________

Name (*last, first, middle initial*): ______________________________

Street Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Date of Birth: _______ - _______ - _________ Phone Number: (_______) _______ - _______________

Proxy Information: (All sections required – please print clearly.)

E-mail Address: ______________________________

Name (*last, first, middle initial*): ______________________________

Street Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Date of Birth: _______ - _______ - _________ Phone Number: (_______) _______ - _______________

Instructions:

√ For adult to adult proxy access where the patient can understand and make his/her health care decisions, complete section A

OR

√ For adult to adult proxy access where the patient can not understand and make his/her health care decisions, complete section B

Section A:

The patient can understand and make his/her health care decisions.
(Patient must show Photo ID)

Proxy:
I acknowledge and agree that:
- I must have my own MyChart account at this institution.
- The Patient can revoke my access to his/her MyChart account at any time.
- I will comply with the terms and conditions on the MyChart web page and this document.

______________________________/______________________/______________/______________
Proxy Signature (required) Relationship to Patient (required) Date (required) Time (required)

Patient:
I acknowledge and agree that:
- I have completed the MyChart Authorization for Use or Disclosure of Electronic Protected Health Information.
- I will comply with the terms and conditions on the MyChart web page and this document. I choose to designate the person named above as a proxy to my MyChart account, thereby allowing him/her access to my MyChart protected health information.
- I understand that if I no longer want the proxy to have access to my MyChart account, I may revoke his/her access by going into my MyChart account under Family Access Settings and clicking the radio button next to their name and click Revoke Access.

______________________________________/______________/______________
Patient Signature (required) Date (required) Time (required)

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Section B:
The patient cannot understand nor make his/her health care decisions.

My Relationship to the Patient is as Follows:

- ❏ Permanent Legal Guardian – Poxy must show Photo ID and must attach a copy of the Court Order Appointing Guardian and Letters of Guardianship verifying the proxy's status as permanent legal guardian.

OR

- ❏ Activated Durable Power of Attorney for Healthcare (DPOA) – Proxy must show Photo ID and must attach a copy of the valid Durable Power of Attorney for Healthcare and Two Physician Certifications verifying the patient lacks decisional capacity.

I acknowledge and agree that:

- I must have my own MyChart account at this institution.
- I will comply with the terms and conditions on the MyChart web page and this document. I have the proper documentation authorizing me as a legal representative for this patient, thereby allowing me access to his/her protected health information through MyChart.
- When my legal authority to act on behalf of the patient has been inactivated, revoked, terminated, or expired, I must immediately notify this institution in writing of the revocation, termination, or expiration and mail it to my physician's office.
- Even if my legal authority to act on behalf of the patient has not been inactivated, revoked, terminated, or expired, my access to this patient's MyChart protected health information will expire three years from the signature date of this document. I will then need to complete this form again to obtain access for another three years.

______________________________/____________________/______________/____________
Proxy Signature (required) Relationship to Patient (required) Date (required) Time (required)

For Official Use:

Section A Completed: I have verified and/or completed the following:

1. The Patient has completed all sections in the Patient Information and Proxy Information sections.
2. The Proxy and the Patient have signed the form under Section A.
3. I have viewed the Patient's photo ID to confirm his/her identity.
4. I have signed and dated the form below.

OR

Section B Completed: I have verified and/or completed the following:

1. The Proxy has completed all sections in the Patient Information and Proxy Information sections.
2. The Proxy has checked one of the boxes in Section B.
3. If the Proxy checked the Permanent Legal Guardian box, I have made copies of the Court Order Appointing Guarding and Letters of Guardianship and will attach the copies to this document.
4. If the Proxy checked the Activated Durable Power of Attorney for Healthcare (DPOA) box, I have made copies to this document.
5. I have viewed the Proxy's photo ID to confirm his/her identity.
6. I have signed and dated the form below.

Confirmed on ________________/ ___________________ by ____
Date Time Signature of TCH Employee

Patient's Medical Record No./EPI: ___________________________