MyChart Proxy Form and
Patient Authorization to Release Protected Health Information to Proxy

Patient's Information (all fields required – please print clearly): Complete this section with information about the patient who's MyChart will be accessed by the proxy.

Name:____ Date of Birth:_________________
(Last, First, Middle Initial)

Street Address:________________________ City:________________________ State:_________ Zip:__________

Phone Number:_______________________________________ E-mail:_____________________________________

Adult Proxy Information (all fields required – please print clearly):

Name:____ Date of Birth:_________________
(Last, First, Middle Initial)

Street Address:________________________ City:________________________ State:_________ Zip:__________

Phone Number:_______________________________________ E-mail:_____________________________________

I, ____________________ (patient name) permit The Christ Hospital Health Network (TCHHN) to release protected health information though MyChart to __________________ (proxy name). I understand that by permitting another person proxy access to MyChart, he or she will view the same information that I may view myself.

I understand that once my records have been released to my proxy, they may be re-disclosed by the proxy and will no longer be protected by federal privacy regulations.

I understand that protected health information that is released through MyChart to my proxy may include information related to the treatment, diagnosis or testing of alcohol or drug abuse, **drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), and/or test for antibodies to the AIDS virus (HIV).**

I further understand that the information that is released through MyChart to my proxy may include information related to medications and use of contraception, sexually transmitted diseases, and or any history of abortion.

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. Also, I understand that I can terminate my authorization to release information to my proxy at any time by informing The Christ Hospital Health Network, 237 William Howard Taft Rd, Cincinnati, OH 45219, and Attention: IT Revenue Cycle Department. This termination of authorization will not apply to records that were previously released.

I understand that I may refuse to sign this Authorization and it will not affect my ability to obtain treatment. If I refuse to sign this Authorization, proxy access will not be granted to the above-named adult at this time.

PATIENT MUST SIGN BELOW:

I understand that my use of MyChart is voluntary and I am not required to use MyChart or to authorize a MyChart proxy. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO CONTACT TCHHN TO REVOKE THE PROXY STATUS WHEN I NO LONGER WANT THE PERSON I DESIGNATED TO HAVE ACCESS TO MY MYCHART HEALTH INFORMATION. By signing below, I acknowledge that I have read and understand this MyChart Proxy Form and Patient Authorization to Release Protected Health Information to Proxy. I agree to its terms and the terms and conditions on the MyChart web page and choose to designate the person named above as my MyChart proxy, thereby allowing him or her access to my MyChart medical record.

____/____________

PATIENT SIGNATURE Date

Printed name of Patient:____

PROXY MUST SIGN BELOW:

By signing below, I acknowledge and agree

- 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 parent or 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 this 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 the patient's physician's office.
- That my access can be revoked at any time by TCHHN for any reason, including my own misuse of MyChart.

_____________________________/____________________/________________/_____________

Proxy Signature Relationship to Patient Date Time

Please return completed form(s) to the office of the patient's provider or hospital department.