Memorial Healthcare System

MyChart Proxy Authorization Form

This form is an authorization that permits Memorial Healthcare System to release your medical information to a designated adult (a "proxy") so that he or she can access your Memorial Healthcare System MyChart records on your behalf. This form must be completed by the patient shown below who is authorizing another adult to access his or her Memorial MyChart. This form must accompany the completed form, Request for Access to an Adult's MyChart. You may obtain a copy of the Request for Access form from your MyChart Provider's Office.

Patient Name (last, first, middle initial)	
Last 4 digits of Social Security Number	
Date of Birth	
Street Address	
City	
State	
Zip Code	
Telephone number	

By signing this, I authorize [Memorial Healthcare System and its facilities, including physician practices], to release to ________________________________(name of individual) health information contained in my Memorial MyChart record. I understand that the information disclosed may include, but is not limited to lab tests [past, present and future], physician office visit summaries, and communications with my healthcare providers.

I acknowledge the following statements:

a. I understand that I may revoke this authorization at any time by utilizing the Family Access Settings from within my MyChart account or by presenting to my MyChart Provider's Office. Such revocation will not have any effect on any action taken by Memorial Healthcare System before the revocation.

b. This authorization will continue until revoked by me, but not longer than (please check one): ___ in six months, or ___ in one year, or ___ indefinitely.

c. I understand that this information may include information relating to: 1) Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection, 2) Mental or behavioral health or psychiatric care, or 3) Treatment of drug or alcohol abuse.

d. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the party who receives it because it may no longer be protected by the federal privacy laws.

For help with this document, please contact your MyChart Provider's Office or email MyChart@mhs.net. Thank you.

e. I understand that records in electronic form can be distributed on a wide scale with relative ease and losses or unintended releases of the requested information may occur under circumstances beyond the control of MHS, or the person making the request. By authorizing access to records in this format, I am knowingly and voluntarily assuming this risk and all of the consequences, losses and damages that might result.

f. I understand that Memorial Healthcare System may not condition treatment, payment, enrollment or eligibility of benefits on the completion of this authorization.

g. This information will be used and disclosed for the purpose of providing the designated individual access to my Memorial MyChart records.

h. I have read and agree to comply with and be bound by the terms of use for MyChart.

Signature of Patient	
Date	

-OR-

Signature of Patient's legal personal representative	
Date	
Printed name of Patient's personal representative	
Telephone Number	
Relationship to Patient/Authority to act for Patient	