MyChart

Adult proxy form

Access to another adult's MyChart record

To request access to the MyChart record of an adult whose health care you help manage, please complete this form. The patient must sign this form and provide authorization for release of medical information in MyChart. Please note that the patient's chart will be accessed through your (the proxy's) MyChart record. Completing this form will establish a MyChart record for you and for the patient.

Return all forms to: MyChart Services or fax 612-262-1424
Mail Route 10607, 2925 Chicago Avenue, Minneapolis, MN 55407

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)* _____

Last 4 digits SSN: _____ Date of birth: _____

Street address: _____ City: _____ State: _____ Zip: _____

Email address: _____ Phone number: _____

Check the box next to the organization that provides your primary care (select one):

- ☐ Allina Health
- ☐ FirstLight Health System
- ☐ Hutchinson Health
- ☐ St. Croix Regional Medical Center
- ☐ Baldwin Area Medical Center
- ☐ Glencoe Regional Health Services
- ☐ River's Edge Hospital & Clinic
- ☐ United Family Medicine
- ☐ Cuyuna Regional Medical Center
- ☐ Grand Itasca Clinic & Hospital
- ☐ Riverwood Regional Medical Center
- ☐ The Urgency Room

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)* _____

Last 4 digits SSN: _____ Date of birth: _____

Street address: _____ City: _____ State: _____ Zip: _____

Email address: _____ Phone number: _____

Check the box next to the organization that provides your primary care (select one):

- ☐ Allina Health
- ☐ FirstLight Health System
- ☐ Hutchinson Health
- ☐ St. Croix Regional Medical Center
- ☐ Baldwin Area Medical Center
- ☐ Glencoe Regional Health Services
- ☐ River's Edge Hospital & Clinic
- ☐ United Family Medicine
- ☐ Cuyuna Regional Medical Center
- ☐ Grand Itasca Clinic & Hospital
- ☐ Riverwood Regional Medical Center
- ☐ The Urgency Room

MyChart terms and agreement

- I understand that MyChart is intended as a secure online source of confidential health information. If I share my username and password with another person, that person may be able to view my or my child's health information, and health 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 confidentiality may have been compromised in any way.
- I understand that it is my responsibility to ensure that my email address is current at all times, and that if my email address is not current I will not receive important messages from MyChart.
- I understand that MyChart contains selected, limited medical information from a patient's health record and that MyChart does not reflect the complete contents of the health record. I also understand that a paper copy of a patient's health record may be requested.
- I understand that my activities within MyChart may be tracked electronically and that entries I make may become part of the medical record.
- I understand that access to MyChart is provided as a convenience to patients and that MyChart Services has the right to end access to MyChart at any time, for any reason.
- I understand that my use of MyChart is voluntary and I am not required to use MyChart or to authorize a MyChart proxy.

▶ _____

Your (proxy) signature **Relationship to patient** **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 health record.

▶ _____

Signature of patient (or authorized person) *(required)* **Relationship to patient** **Date** *(required)*

MyChart

Adult proxy authorization for release of medical information

This form is an authorization that will permit your clinic to release your health information to your designated adult proxy. Please read it carefully.

This form should be completed by the patient who is authorizing another adult to access health information in his or her MyChart record. 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. If you do not have an adult proxy form, please download one from www.allinahealth.org/proxy.

Name *(last, first, middle initial)* _____

Last 4 digits SSN: _____ Date of birth: _____

I am requesting that _____ *(insert name of proxy)* receive access to my health information that is available in MyChart. This person is my designated MyChart proxy. I authorize MyChart 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 health record and may include information from all facilities listed in Notice of Privacy Practices. I authorize release of any information contained in my MyChart to my designated proxy. I authorize release of this information only through my MyChart record. This form does not authorize release of my health 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 the same 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 MyChart 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, MyChart is not permitted to provide my designated proxy access to my MyChart record. This authorization will expire automatically five years from the date of my signature. I also may cancel this authorization at any time online in MyChart or by providing a written request for cancellation to my primary clinic. I understand that if I cancel this authorization, my designated proxy's access to my MyChart record will be ended. I also understand my cancellation will not affect any disclosures that were made prior to processing the revocation before my cancellation request is processed.

Date: _____

Check the box next to the organization that provides your primary care (select one):

- ☐ Allina Health
- ☐ FirstLight Health System
- ☐ Hutchinson Health
- ☐ St. Croix Regional Medical Center
- ☐ Baldwin Area Medical Center
- ☐ Glencoe Regional Health Services
- ☐ River's Edge Hospital & Clinic
- ☐ United Family Medicine
- ☐ Cuyuna Regional Medical Center
- ☐ Grand Itasca Clinic & Hospital
- ☐ Riverwood Regional Medical Center
- ☐ The Urgency Room

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 five years from the date of signature (above). This release of medical information form must be submitted every five years 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 primary clinic.