Atlantic Health System

DT2208

PATIENT ID HERE

ADULT PROXY AUTHORIZATION FORM

Authorization Granting Access to MyChart Medical Record

In signing this form, you agree the person listed below can have full access to your electronic health information through MyChart patient portal application. "Proxy" is a person who is granted access to another individual's medical record. Proxy and the Patient must sign this form. Completing this form will establish a MyChart record for the Proxy and Patient (if they do not have a MyChart account).

In addition, the patient must sign a separate authorization for release of medical information to the Proxy (called the "Adult Proxy Authorization Form.") in page 2.

You must include a government issued photo ID, for both yourself and the patient. Return (or fax) all forms to your physician's office or email to MyChart.HIM@atlantichealth.org

This section should be completed by the individual requesting access to another adult's MyChart record.

PERSON SEEKING ACCESS/PROXY: ***(All sections required - please print clearly)***

Name *(last, first, middle initial)*: _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Home Phone Number: _____

Have you ever received any services at Atlantic Health System? ☐ YES ☐ NO

Complete this section with information about the patient whose MyChart record the proxy is requesting access.

PATIENT: ***(All sections required - please print clearly)***

Name *(last, first, middle initial)*: _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Home Phone Number: _____

MyChart Terms and Agreement

- I understand that MyChart is intended to provide limited access to confidential medical information. If I share or allow my MyChart ID and password to be disclosed to another person, that person may be able to view my health information, and information about someone who has authorized me as a MyChart proxy and transmit that information to a third party.
- 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 it may have been compromised in any way.
- I understand that MyChart contains selected, limited medical information from a patient's medical record and that MyChart does not reflect the complete contents of the medical record. I also understand that a paper copy of a patient's medical record may be requested from the Health Information Department of Atlantic Health System.
- I understand that access to MyChart is provided by my physician's office/Atlantic Health System as a convenience to its patients and that my physician's office/Atlantic Health System has the right to deactivate access to MyChart at any time for any reason. I understand that use of MyChart is voluntary and I am not required to use MyChart or to authorize a MyChart proxy.

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- I understand that while Atlantic Health System will use reasonable security efforts, no system can guard against all risks of intentional intrusion or inadvertent disclosure medical information on MyChart. MyChart transmits medical information over the internet, a medium that is beyond the control of Atlantic Health System and its contractors. I HEREBY EXPRESSLY ASSUME THE SOLE RISK OF ANY UNAUTHORIZED DISCLOSURE OR INTENTIONAL INTRUSION, OR OF ANY DELAY, FAILURE, INTERRUPTION OR CORRUPTION OF DATA OR OTHER INFORMATION TRANSMITTED RELATING TO THE USE OF THIS SERVICE.
- MyChart allows patients and proxies the ability to use confidential messaging. You can elect to message a physician and prevent others from viewing the correspondence.
- You should not make any decision relating to your health based upon the information available in MyChart and/or in your medical record. You always should consult with your physician for health-related matters.
- **I have read, understand and agree to the terms and conditions set forth on this page, as well as the terms and conditions included on the webpage used to access MyChart** - https://mychart.atlantichealth.org/mychart/

Signature of Proxy: _____ Date: _____ Time: _____

Relationship to Patient: _____

Signature of Patient: _____ Date: _____ Time: _____

(or authorized person)

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This form is an authorization that will permit your physician's office/Atlantic Health System to release your medical information to your designated adult proxy. Please read it carefully.

This form must be completed by the patient who is authorizing another adult to access medical information in the patient's MyChart record. It must accompany a fully completed 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.

Patient Name *(last, first, middle initial)*: _____ Date of Birth: _____

I request that _____ (insert name of proxy) be provided access to my health information that is available in my Atlantic Health System MyChart. This person is my designated MyChart proxy. I authorize Atlantic Health System and its contractors 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 medical record and may include information from other facilities. I authorize release of all information contained in my MyChart medical record held by Atlantic Health System to my designated proxy.

I authorize release of this information only through my MyChart record. This form does not authorize release of my medical 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 to a third party and the disclosed information may not be covered by legal privacy protections.

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), infection with Human Immunodeficiency Virus (HIV), behavioral or mental health services, and/or treatment for alcohol or drug abuse.

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 Atlantic Health System 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, Atlantic Health System is not permitted to provide access to my MyChart record to my designated proxy.

I may revoke this authorization at any time by providing a written request for revocation to my physician's office/Atlantic Health System or through my MyChart account. I understand that if I revoke this authorization, my designated proxy's access to my MyChart record will be ended. I also understand my revocation will not affect any disclosures that were made prior to processing the revocation request.

Signature of Patient *(or authorized person)*: _____ Date: _____ Time: _____

Printed Name: _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip: _____

If person other than the patient signs, indicate authority to sign for patient (e.g. guardian) and attach documentation:

_____

NOTE: You may revoke the access of the adult proxy specified above at any time through MyChart or by providing a written request to your physician's office/Atlantic Health System.

FOR OFFICE USE ONLY:

Received by: _____ Department: _____

*__Examples of ID:__ 1. Government issued photo ID (e.g. driver's license, passport, non-driver ID)

*__Disclaimer:__ Incomplete email requests, without all ID requirements attached will not be processed. Must re-submit request with all attached ID requirements.