Adult Proxy Authorization for Release of Medical Information
MyChart Adult Proxy Form

Access to Another Adult's MyChart Record

To request access to the MyChart record of an adult whose medical care you help manage, please complete this form. The patient must sign this form and provide authorization for release of medical information in MyChart on the "Adult Proxy Authorization Form." 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. In the case of Power of Attorney (POA), an adult individual can gain access by providing appropriate POA documentation to the treating physician.

Return forms to your **Primary Care Provider** Office.

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*):_____ Date of Birth:_____

Social Security Number:_____ Email:_____

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

Phone Number:_____ Primary Clinic: _____

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

Complete this section with information about the patient whose MyChart record you're requesting to access.

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

Social Security Number:_____ Email:_____

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

Phone Number:_____ Primary Clinic: _____

MyChart Terms and Agreement

By signing below, I acknowledge that I have read, understand, and agree to the MyChart Terms and Conditions.

A copy of the MyChart Terms and Conditions can be requested at your physician's office and can be obtained online at https://mychart.fmolhs.org

▶ _____ __/__/____ __/__/____ __/__/____

Your (Proxy) Signature (*Required*) **Relationship to Patient** **Date** **Time**

I acknowledge that I have read and understand this MyChart Sign-up 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 medical record.

▶ _____ __/__/____ __/__/____ __/__/____

Signature of Patient (or authorized person) (*Required*) **Relationship to Patient** **Date** **Time**

Adult Proxy Authorization for Release of Medical Information

This form should be completed by the patient who is authorizing another adult to access medical 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 contact your clinic, or download one from https://mychart.fmolhs.org.

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

Social Security Number: _____ Date of Birth: _____

I am requesting that_____*(insert name of proxy)* receive access to my health information that is available in my FMOLHS MyChart Record. This person is my designated MyChart proxy. I authorize Our Lady of the Angels Hospital, Our Lady of the Lake Regional Medical Center, Our Lady of Lourdes Regional Medical Center, St. Francis Medical Center, St. Dominic Jackson Memorial Hospital, Senior Services, Health Centers in Schools, Affiliated Organization Physician Groups, Health Leaders Network Next Generation ACO, Community Connect and RX One to release the health information contained in my MyChart record to my MyChart proxy. I understand that this list is not all inclusive. I understand that the medical information in MyChart is obtained from my electronic medical record and may include information from all facilities listed in FMOLHS's Notice of Privacy Practices. I authorize release of any information contained in my MyChart medical record held by Our Lady of the Angels Hospital, Our Lady of the Lake Regional Medical Center, Our Lady of Lourdes Regional Medical Center, St. Francis Medical Center, St. Dominic Jackson Memorial Hospital, Senior Services, Health Centers in Schools, Affiliated Organization Physician Groups, Health Leaders Network Next Generation ACO, Lake Charles Memorial Health System, Community Connect and RX One 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 and the disclosed information may not be covered by federal 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 the above listed entities do 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, the above listed entities are not permitted to provide access to my MyChart record to my designated proxy.

This authorization will expire automatically one year from the date of my signature. I also may revoke this authorization at any time by providing a written request for revocation to my primary clinic. 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.

Date:_____Primary Clinic: _____

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 one year from the date of signature (above). A new *MyChart Proxy Authorization Form* must be submitted each year 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.