MyChart Adult Proxy Form

PATIENT Information (Please print)

Patient Name: _____ _____/_____/_____
Last First Middle Date of Birth

Address: _____
Street City State Zip

Social Security # (last 4 digits): XXX-XX-_____ Phone number: _____

PROXY Information

Proxy Name: _____ _____/_____/_____
Last First Middle Date of Birth

Have you been registered under a different name? _____

Address: _____
Street City State Zip

Social Security # (last 4 digits): XXX-XX-_____ Phone number: _____

Email address (Required): _____

Choose one (1) applicable MyChart access below

☐ **Capable Adult Patient:** **Includes emancipated minor – must have proof of emancipation*

- Patient who is authorizing another adult to access their medical information through MyChart.
- Authorization expires upon death. Access may be revoked at any time by the patient, proxy, or Healthcare System.

☐ **Incapacitated Adult Patient:** **Legal documentation must be present in patient chart*

Select one of the options below:

☐ Power of Attorney for Health Care

☐ Legal Guardian

By signing this form:

- I understand that OSF HealthCare System has been contracted by my provider to provide its electronic health record system, including MyChart.
- I understand that participation in MyChart and designating a proxy is completely voluntary. I understand that I am not required to designate a proxy and I am not required to provide this authorization. I also understand that my provider does not condition any of my health care treatment, payment, or other services whether I provide this authorization. However, I also understand that if I do not provide authorization, my provider is not permitted to provide access to my MyChart account to my designated proxy. I authorize my provider to allow access to the health information contained in my MyChart account to my designated proxy.
- I understand that the medical information in MyChart is obtained from my electronic medical record and may contain sensitive information including, but not limited to, HIV/AIDS related health information and/or records, behavioral or mental health information and/or records, information about sexually transmitted disease (STD), pregnancy, birth control, drugs/alcohol diagnosis, treatment, and/or referral information, genetic testing information and/or records, information about sexual assault/abuse, and information about child abuse and neglect, etc. from all facilities listed in my provider's notice of privacy practices [and OSF HealthCare System Notice of Privacy Practices].
- I understand that a proxy has the same access to message providers, request prescription refills, schedule appointments, and any other information the patient has access to in MyChart.
- I authorize access to all existing and future information contained in my MyChart account held by my provider by my designated proxy.
- I understand this authorization expires upon death. Access may be revoked at any time by the patient, proxy, or my provider.

I acknowledge that I have read and understand this form and I agree to its terms. I further agree to any and all current and future terms and conditions noted at https://www.mychart.org.

_____ / _____/_____/_____
Patient Signature (Required if capable adult) Date (Required)

_____ /_____ / _____/_____/_____
POA/Legal Guardian Signature (Required if incapacitated adult) Relationship to patient (Required) Date (Required)

_____ / _____/_____/_____
Employee Signature #1 (Required) Date (Required)

_____ / _____/_____/_____
Employee Signature #2 (Two witnesses required for verbal request) Date (Required)