Adult to Adult MyChart® Record Proxy Release of Information Authorization
(To be completed by the Patient)

This form is your acknowledgment and approval to permit your healthcare provider ("Provider") to release your medical information to your designated proxy. Please read it carefully.

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

Patient Last 4 digits of Social Security Number:_____Patient Date of Birth: _____

I am requesting that the following individual receive access to all of my health information that is available in my MyChart® Record:

Name of Proxy: _____ Proxy Date of Birth: _____

Proxy Home Address: _____

Proxy Phone Number: _____

This person is my designated MyChart® proxy. I acknowledge my Provider will release to my MyChart® proxy, all records and other information in MyChart® regarding my treatment, hospitalization, and outpatient care for my impairment(s), including but not limited to:

- Psychological, psychiatric, or other mental impairment(s) (excludes "psychotherapy notes: as defined in 45 CFR 164.501)
- Drug abuse, alcoholism, or other substance abuse
- Sickle cell anemia
- Records which may indicate the presence of a communicable or non-communicable disease; and test for or records of HIV/AIDS or sexually transmitted diseases
- Gene-related impairments (including genetic test results)
- Family history
- Medical information in MyChart® that is obtained from my electronic medical record and may include information from other providers or health care facilities described in my Provider's Notice of Privacy Practices.

I approve of release of any information contained in my MyChart® Record held by my Provider to my designated proxy only through my MyChart® Record. This form does not permit 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 voluntary. I understand that I am not required to designate a MyChart® proxy and I am not required to provide this acknowledgement and approval. I also understand that my Provider does not condition any of my health care treatment, payment or other services on whether I provide this acknowledgement or approval. However, I also understand that if I do not provide acknowledgement and approval my Provider is not permitted to provide access to my MyChart® record to my designated proxy.

I understand that I may revoke access to my Proxy access at any time without contacting my provider through the MyChart Portal - https://www.franciscanmychart.org

► _____ _____ _____

Signature of Patient/Patient Representative | Relationship to Patient | Date

Description of Authority to act for Patient (if applicable): _____

This form should be completed by the patient acknowledging and approving proxy access to medical information in his or her MyChart® record. It must accompany the MyChart Proxy Access Informed Consent form, which provides the name and information of the individual who the patient is acknowledging and approving access to his or her MyChart record as a proxy.

I have assessed the patient and the patient does not have decisional capacity for medical decisions and I anticipate that this will be persistent.

► _____ _____ _____

Signature of Physician | Printed Physician Name | Date