Adult Proxy Form

MyChart is a service provided by OSF Healthcare System.

Access to Another Adult's MyChart Account

To request access to the MyChart account of an adult whose medical care or payment of care you manage, please complete both pages of this form. The patient must sign this form and provide authorization on page 2 via the "Adult Proxy Authorization for Access to Medical Information" form. The patient's account will be accessed through your (the proxy's) MyChart account. Completion of this form is required before we can establish a MyChart account for you and access to the patient's information. Return forms to your healthcare provider.

Please enter Patient's Information below: (All fields are required – please **print** clearly).

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

Last Four Digits of Social Security Number: XXX-XX-_____

Date of Birth: _____ Gender: _____Male _____Female

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

Provider's Name/Office: _____

Proxy Information: (All fields are required – please **print** clearly.)

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

Last Four Digits of Social Security Number: XXX-XX- _____ Gender: _____Male _____Female

Date of Birth: _____ Phone Number: _____

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

Email address:_____

MyChart Terms and Agreement

- I understand that OSF Healthcare System has been contracted by my provider to provide MyChart.
- I understand that MyChart is intended as a secure online source of confidential medical information. If I share my MyChart ID 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 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 complete medical record may be requested from the applicable provider.
- I understand that my activities within MyChart may be tracked by computer audit and that entries I make may become part of the patient's medical record.
- I understand that OSF Healthcare System has been contracted to provide me with access to MyChart and that OSF Healthcare System and/or my physician 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.
- By signing below, 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 on the MyChart site.

▶ _____ / _____ / _____

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

I acknowledge that I have read and understand this form. I agree to its terms and conditions above.

▶ _____ / _____ / _____

Signature of Proxy (*Required*) **Relationship to Patient** **Date**

Adult Proxy Authorization for Access to Medical Information

This form is an authorization that will allow access to your medical information available in MyChart to your designated adult proxy. Please read it carefully.

This form should be completed by the patient who is authorizing another adult to access medical information in his or her MyChart account. 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 account as a proxy.

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

Date of Birth: _____

I am requesting that _____ *(print name of proxy),* who I agree is involved in my care, or the payment of my care, and whose birth date is _____ receive access to my health information that is available in my MyChart account. This person is my designated MyChart proxy. I authorize access of the health information contained in my MyChart account to my MyChart proxy. I understand that the medical information in MyChart is obtained from my electronic medical record and may include sensitive medical information including information related to mental health, alcohol or drug abuse conditions, developmental disabilities, etc. I authorize access to all currently existing and future information contained in my MyChart account to my designated proxy.

I understand and agree that my proxy is my designated personal representative who may communicate freely with, and receive communication from, my physician and his/ her office staff on my behalf.

I understand that once information has been accessed, it potentially may be disclosed by the proxy. Information disclosed by your proxy 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 my provider 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, my provider is not permitted to provide access to my MyChart account to my designated proxy.

This authorization will not expire until my death unless I revoke this authorization, or the designated proxy resigns their position. Either person may revoke access at any time. I understand that if I revoke this authorization, my designated proxy's access to my MyChart account will end. I also understand my revocation will not affect access to any information that was made prior to processing the revocation request; the change will take several days to process.

Date: _____ Physician's Name: _____

Signature of Patient (or authorized person): _____

Printed Name: _____

Staff Use Only. Mark the box to indicate authority for when person other than the patient signs (e.g. guardian) and verify appropriate documentation is present in the patient chart.

☐ POA on file ☐ Guardianship papers on file Staff Signature: _____