

## Proxy REVOCATION Form

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MyChart is a service provided by OSF Healthcare System.

I am the patient. I wish to revoke Proxy access that I previously authorized as indicated below.

I am a proxy. I wish to revoke Proxy access that was granted to me for the patient identified below.

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

Name (*last, first, middle initial*): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Male \_\_\_\_\_ Female

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Provider's Name: \_\_\_\_\_

Provider's Office: \_\_\_\_\_

**Proxy's Information:** (All sections are required - please **print** clearly.)

Name (*last, first, middle initial*): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Per the agreement I signed on the Proxy access to an MyChart *Account* form, I submit this request to revoke the above named proxy's access to the above named patient's MyChart account. I understand it may take up to 7 days for the proxy's access to be cancelled. I further understand, if I am not the proxy, it is my responsibility to notify the proxy of this revocation. My provider will not notify the proxy.**

▶ \_\_\_\_\_  
Print Name

▶ \_\_\_\_\_ / \_\_\_\_\_  
Signature Date (Required)

▶ \_\_\_\_\_ / \_\_\_\_\_  
Witness Signature (anyone other than the parent or patient may witness) Date (Required)