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.

Return forms to this to be scanned into your Electronic Record.

Health Information Management Services
Texas Health Resources
500 E. Border St – Suite 700
Arlington, TX 76010
HIMSROI@texashealth.org
or Fax to: 682-236-7126

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 _____

Sex:_____ Email: _____

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

Phone Number: _____ Primary Physician: _____

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 _____

Sex:_____ Email: _____

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

Phone Number: _____ Primary Physician: _____

MyChart Terms and Agreement

- I understand that MyChart is intended as a secure online source of confidential medical information. My MyChart ID and password cannot be shared with anyone because that person will be able to view my health information, and health information about someone who has authorized me as a MyChart proxy. This action will result in the deactivation of my MyChart account.
- 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 copy of a patient's medical record may be requested from the patient's clinic.
- 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 access to MyChart is provided by Texas Health Resources as a convenience to its patients and that Texas Health Resources 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 MyChart Sign-Up Form and I agree to its terms.

▶ _____ / _____ / _____

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

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.

Authorization for Release of Medical Information

Texas Health Resources

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

This form is an authorization that will permit Texas Health Resources to release your medical information 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 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.

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

Date of Birth: _____

I am requesting that _____ *(insert name of proxy)* receive access to my health information that is available in my Texas Health Resources MyChart Record. I understand that the specified information to be released may include: personal lab results, demographics, problem list and medical information. This person is my designated MyChart proxy. I authorize Texas Health Resources to release the health information contained in my MyChart record to my MyChart proxy. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). 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 Texas Health Resources 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, Texas Health Resources is not permitted to provide access to my MyChart record to my designated proxy.

This authorization will not expire until I revoke by providing a written request for revocation to Texas Health Resources. 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 *(Required)*: _____ Primary Physician: _____

Signature of Patient (or legally authorized representative): _____

Printed Name: _____

If person other than the patient signs, indicate authority to sign for patient (e.g., guardian) and attach documentation:

NOTE: You may deactivate the access of the adult proxy specified above at any time through MyChart or by providing a written request to your clinic.