MyChart Proxy Access Form

Access to a patient's MyChart Record

To request access to the MyChart record of a patient whose medical care you help manage, please complete this 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.

Patient 1 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 _____

Last 4 digits of SSN: _____ Email: _____

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

Phone Number: _____ Primary Physician: _____

Patient 2 Information

Complete this section with information about the patient whose MyChart record you're requesting to access.

Name (*last, first, middle initial*) _____ Date of Birth _____

Last 4 digits of SSN: _____ Email: _____

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

Phone Number: _____ Primary Physician: _____

Patient 3 Information

Complete this section with information about the patient whose MyChart record you're requesting to access.

Name (*last, first, middle initial*) _____ Date of Birth _____

Last 4 digits of SSN: _____ Email: _____

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

Phone Number: _____ Primary Physician: _____

Patient 4 Information

Complete this section with information about the patient whose MyChart record you're requesting to access.

Name (*last, first, middle initial*) _____ Date of Birth _____

Last 4 digits of SSN: _____ Email: _____

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

Phone Number: _____ Primary Physician: _____

Proxy Information (All sections required – please print clearly.)

This section should be completed by the individual(s) requesting access to a patient's MyChart record.

Name(s) (*last, first, middle initial*) _____ Date(s) of Birth _____

Last 4 digits of SSN(s): _____ Email(s): _____

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

Phone Number: _____

Authority of Proxy

___ Patient is a minor and I am the patient's parent and natural guardian. My rights to seek medical information on the minor patient have not been limited by court order.

___ Patient is a minor and I am the patient's guardian. See attached order which is still in effect.

___ Patient is an incapacitated person and I am the patient's guardian. See attached order which is still in effect.

___ I am the patient's agent. See attached document which is presently in effect.

___ Other: _____

MyChart terms and agreement

- 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. Due to state or federal regulations certain medical information may not be available. MyChart does not include physician notes. MyChart may include prescription medications and reason for provider visits past and future.
- 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 Altru Health System as a convenience to its patients and that Altru Health System 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.

Proxy:
I acknowledge and agree that:

- The patient can revoke my access to his/her MyChart account at any time.
- If the patient is under age 18, proxy access will be deactivated on the patient's 18th birthday.
- I will comply with the terms and conditions on the MyChart web page and this document.
- When my legal authority to act on behalf of the patient has been inactivated, revoked, terminated or expired, I must immediately notify Altru Health System in writing of the revocation, termination or expiration and mail it to: Altru Health System, Attn: MyChart Medical Records, 1200 South Columbia Road, P.O. Box 6002, Grand Forks, ND 58206-6002.

▶ _____ / _____ / _____

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

▶ _____ / _____ / _____

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

Patient:
I acknowledge and agree that:

- I must have my own MyChart account with Altru Health System
- I will comply with the terms and conditions on the MyChart web page and this document.
- I choose to designate the person named above as a proxy to my MyChart account, thereby allowing him/her access to MyChart protected medical information. I authorize release of any information contained in my MyChart medical record held by Altru Health System to my designated proxy. I understand that the medical information in MyChart is obtained from my electronic medical record and may include information from all facilities listed in Altru Health System's Notice of Privacy Practices.
- 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 Altru Health System 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, Altru Health System is not permitted to provide access to my MyChart record to my designated proxy.
- I understand that if I no longer want the proxy to have access to my MyChart account, I may revoke his/her access in my MyChart account under My Family's Records or in writing by sending a request to: Altru Health System,

  Attn: MyChart Medical Records, 1200 South Columbia Road, P.O. Box 6002, Grand Forks, ND 58206-6002.
- 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.

▶ _____ / _____ / _____

Signature of Patient **Relationship to Proxy** **Date**

Patient signature not required when patient is under the age of eighteen or proxy has legal authority. Please attach relevant document(s).

Altru patients - return forms to:
Altru Health System, Attn: MyChart Medical Records
1200 South Columbia Road, P.O. Box 6002
Grand Forks, ND 58206-6002

☐ ROI use only
Approved by Medical Records

Altru patients - fax forms to:
701-780-1047
701-780-5387

Non-Altru patients – return forms to your medical facility's medical records office