WESTERN WISCONSIN HEALTH

MyChart

Adult Proxy form

Access to another adult's MyChart record

To request access to the MyChart record of another adult whose health care you help manage, please complete this form. The patient must sign this form and provide authorization for release of medical information in MyChart. Please note that the patient's chart will be accessed through your (the proxy's) MyChart record. Completing this form will establish a MyChart for you and for the patient.

Return all forms to: Health Information Management or fax: 715-684-1594
1100 Bergslien Street, Baldwin, WI 54002

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):* ____

Last 4 digits SSN: ____________________________ Date of birth: ____________________

Street address: _________________________ City: ______________ State: ____ Zip: _______

Email address: ______________________________ Phone number: __________________

Check the box next to the organization that provides your primary care (select one):

☐ Western Wisconsin Health ☐ Other: ______________________________

Patient's information: (all sections required – please print clearly)

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

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

Last 4 digits SSN: ____________________________ Date of birth: ____________________

Street address: _________________________ City: ______________ State: ____ Zip: _______

Email address: ______________________________ Phone number: __________________

Check the box next to the organization that provides your primary care (select one):

☐ Western Wisconsin Health ☐ Other: ______________________________

MyChart terms and agreement

- I understand that MyChart is intended as a secure online source of confidential health information. If I share my username 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 confidentiality may have been compromised in any way.
- I understand that it is my responsibility to ensure that my email address is current at all times, and that if my email address is not current, I will not receive important messages from MyChart.
- I understand that MyChart contains selected, limited medical information from a patient's health record and that MyChart does not reflect the complete contents of the health record. I also understand that a paper copy of a patient's health record may be requested.
- I understand that my activities within MyChart may be tracked electronically and that entries I make may become part of the medical record.
- I understand that access to MyChart is provided as a convenience to patients and that MyChart Services has the right to end access to MyChart at any time, for any reason.
- I understand that my use of MyChart is voluntary and I am not required to use MyChart or to authorize a MyChart proxy.

____

Your (proxy) signature **Relationship to patient** **Date** *(required)*

I acknowledge that I have read and understand this MyChart Adult proxy 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 health record.

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Signature of patient (or authorized person) **Relationship to patient** **Date** *(required)*

MyChart

Adult proxy authorization for release of health information

This form is an authorization that will permit your clinic to release your health information to your designated proxy. Please read it carefully.

This form should be completed by the adult patient who is authorizing another adult to access health information in his or her interactive health 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 interactive health record as a proxy. If you do not have an adult proxy form, please download one from www.wwhealth.org/mychart

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

Last 4 digits SSN: ______________________________ Date of birth: ________________

I am requesting that ________________________________ *(insert name of proxy)* receive access to my interactive health record. This person is my designated proxy. I authorize MyChart to release the health information contained in my interactive health record to my proxy. I understand that the medical information is obtained from my electronic health record and may include information from all facilities listed in Notice of Privacy Practices. I authorize release of any information contained in my interactive health record to my designated proxy. I authorize release of this information only through my interactive health record. This form does not authorize release of my health 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 the same privacy protections. Accessing my interactive health account and designating a proxy is completely voluntary. I understand that I am not required to designate a proxy and I am not required to provide this authorization. I also understand that Allina Health or its affiliate Western Wisconsin Health 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, MyChart is not permitted to provide my designated proxy access to my interactive health record. This authorization will expire automatically five years from the date of my signature. I also may cancel this authorization at any time online in MyChart or by providing a written request for cancellation to my primary clinic. I understand that if I cancel this authorization, my designated proxy's access to my interactive health record will be ended. I also understand my cancellation will not affect any disclosures that were made prior to processing the revocation before my cancellation request is processed.

Check the box next to the organization that provides your primary care (select one):

☐ Western Wisconsin Health ☐ Other: ______________________________

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Signature of patient (or authorized person) **Date** *(required)*

Printed Name: ____

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

____

NOTE: Authorization expires five years from the date of signature (above). This release of health information form must be submitted every five years to renew proxy access. You also may deactivate the access of the adult proxy specified above at any time through MyChart or by providing a written request to your primary clinic.

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