

MyChart Adult Proxy Access Form

We are pleased to offer caregivers, legal guardians or specifically authorized adults online access to the medical record of another adult whose medical care they help manage. To request access, please complete this form. The patient must sign this form and provide authorization for release of medical information in MyChart. If the patient is not competent to sign on his/her own behalf, we will require documentation of guardianship or a power of attorney for healthcare decisions.

Revoking Proxy Access

An adult granting access may revoke this consent at any time by submitting a written request to his/her physician's office or the **Pacific Medical Centers - Health Information Management Department at 206-621-4150**.

Patient Information

(All information is required – please print clearly.)

Name (last, first, mi): _____ Date of Birth: _____ SSN: _____ - _____ - _____

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

- I understand that for all medical emergencies, I need to immediately dial 911.
- I understand that the health information included in MyChart may include information considered very personal, including information about sexually transmitted and other communicable diseases, drug and alcohol abuse, HIV/AIDS, and mental health services. My health care provider, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I understand that this authorization will continue until revoked. I may revoke this authorization by written request at any time by contacting my provider or the Pacific Medical Centers- Health Information Management Department.
- I understand that the revocation will not apply to the information that has already been released in response to this authorization.
- I understand that failure to comply with the MyChart Terms and Conditions may result in the termination of MyChart access privileges.
- I understand that my provider will not condition treatment on my signing this authorization.
- I understand this authorization must be filled out completely and signed and dated. A copy that has not been altered will be considered as valid as the original.
- I acknowledge that I have read and understand this Adult Proxy Access form and that the full MyChart Terms and Conditions are available to me online. I agree to its terms and choose to designate the person named below as my MyChart Proxy, thereby allowing them access to my MyChart. I further acknowledge that I have processed an appropriate authorization for release of medical information form.

Signature of Patient (or authorized person) : _____
Relationship to patient (if applicable) _____
Date

Proxy's Information (Adult requesting access)

(All information is required – please print clearly.)

Name (last, first, mi): _____ Date of Birth: _____ SSN: _____ - _____ - _____

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

Phone Number: _____

Relationship to patient: Spouse Adult Child Caregiver Legal Guardian
 Durable Power of Attorney for Healthcare Other _____

Are you also a patient with us? Yes No If yes, do you have a MyChart account? Yes No

For Adult Proxy requesting access to another adult's MyChart Medical Record:

- I have read and understand the information about proxy access for MyChart and have access to MyChart Terms and Conditions online.
- I request access to the above patient's MyChart account.

Accessing Adult Signature (Proxy) _____
Relationship to Patient _____
Date

Patient MRN (For Office Use Only): _____