METHODIST HOSPITALS MyChart **Adult Proxy Authorization Form**

Health Information Management Department
600 Grant Street, Gary, IN 46402 | 8701 Broadway Merrillville, IN 46410
Hours: 8am-4pm Monday - Friday
Phone: (219) 738-5586 | **Fax:** (219) 738-6616

Patient Name _____ Date of Birth _____

Patient Address _____ City _____ State _____ Zip_____

Patient Email _____ Phone _____

I understand the MyChart is an Internet application that supports patient access to portions of my electronic healthcare record, electronic communications and other online services. I understand that MyChart is NOT to be used in an emergency.

I understand that authorizing proxy access will allow the person named below to my personal health information. This authorization permits access to any care provided prior to the date of the authorization as well as any care and treatment provide while the authorization is valid. I understand that my proxy will have access to the following information about myself; this may include, but is not limited to:

- Laboratory results (that have been released to MyChart)
- Ability to communicate to my providers and provider's care team regarding my care and treatment through MyChart
- Ability to review and request appointments
- Request renewals on my prescriptions
- View summary information about my medical history

The reason for this access authorization is for my proxy to play a role in my healthcare. I understand that additional information may be made available to my proxy through MyChart as this application advances.

I understand that all activities within MyChart are tracked by computer audit and that entries my proxy makes can become part of my permanent medical record.

I understand that this authorization will expire within two years, unless otherwise specified.

I understand that by signing this agreement I am providing Methodist Hospitals, Inc. documentation of my authorization to provide proxy access to my MyChart account. I understand that a written request must be made to revoke this authorization and that any actions taken or accessed prior to that revocation were authorized as part of the initial signature and date.

I understand that MyChart is optional/voluntary and that my Methodist Hospitals, Inc. and my provider has the right to deactivate access to MyChart for unauthorized or inappropriate actions made by my proxy.

Having read this authorization, I hereby agree to abide by the terms of this agreement and grant proxy access to my personal health information via MyChart to the individual named below.

Proxy Name _____ Proxy Date of Birth _____

Proxy Relationship to Patient _____ Proxy Phone _____

Proxy Address _____ City _____ State _____ Zip _____

Expiration Date: 6 months 12 months 18 months 24 months
(Please circle the expiration time frame. Authorization will expire in 24 months if not specified. The date when proxy access is given will be used to determine expiration date not the signature date of the this form.)

▶ _____ / _____

Signature of Patient/Guardian **Date** *(Required)*