

**Adult**

**Proxy**

## MyChart Access- Adult Patient Proxy Authorization

### 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 (proxy's) MyChart record. Completing this form will establish a MyChart record for you and for the patient.

**All sections required - Please Print clearly.**

**Patient Information:** information about patient whose MyChart record you're requesting to access.

Patient Name: *last*, \_\_\_\_\_ *first*, \_\_\_\_\_ *middle initial*, \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Last 4 digits of SSN: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_  
 Primary Physician: \_\_\_\_\_


**Proxy Information:** information about the individual requesting access to the patient's MyChart record.

Patient Name: *last*, \_\_\_\_\_ *first*, \_\_\_\_\_ *middle initial*, \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Last 4 digits of SSN: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**Proxy:**

**I acknowledge and agree that:**


The patient can revoke my access to his/her MyChart account at any time. I will comply with the terms and conditions on the MyChart webpage. 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 to: Altru Health System, Attn: MyChart Medical Records, 1200 South Columbia Road, P.O. Box 6002, Grand Forks, ND 58206-6002.

 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Signature of Proxy (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. I choose to designate the above names 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 my information only through MyChart record. I understand that once information has been disclosed, it potentially may be re-disclosed by the proxy. I understand that participation in MyChart is completely voluntary, 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 end.

 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Signature of Patient
Relationship to proxy
Date