Mercyhealth™
A passion for making lives better.™

# Mercyhealth MyChart Adult Proxy Request Form

**Access to another adult's *Mercyhealth MyChart* record**
To request access to the *Mercy MyChart* account of an adult patient, please complete this form. This form is valid until revoked by the patient in writing to Mercy Health System. **Please print clearly.**

**Mail or Fax forms to:** MyChart Support
1236 Barberry Dr
Janesville WI 53546

Fax: 608-314-8722

Contact Support: 888-99MYCHART or 888-996-9242

## Proxy Information (Person requesting access)

Name of Proxy:_____ Date of Birth: ____/____/_____
(*last, first, middle initial*)

Street Address: _____City: _____ State: _____ Zip: _____

Email: _____ Phone Number: _____

## Patient's Information (Person authorizing *MyChart* access)

Name of Patient:_____Date of Birth: ____/____/_____
(*last, first, middle initial*)

Street Address: _____City: _____ State: _____ Zip: _____

Email: _____ Phone Number: _____

Relationship to patient:
☐ Legal Guardian ** ☐ Power of Attorney for Healthcare (POA) ** ☐ Other (specify) _____
** Please provide a copy of legal paperwork verifying this information if not already on file.

### Mercyhealth MyChart Terms and Agreement

- ⌘ I understand that *Mercyhealth MyChart* is intended as a secure online source of medical information and contains a limited amount of medical information from a patient's electronic medical record from all Mercyhealth facilities. It does not reflect the complete contents of the medical record. Access may include information related to behavioral or mental health, developmental disabilities, HIV/AIDS, treatment for substance use disorder, genetic testing and counseling, sexual assault/abuse, child abuse, sexually transmitted illness, pregnancy and birth control.
- ⌘ I understand if I share my *Mercyhealth MyChart* ID and password with another person, that person may be able to view my information and health information about someone who as authorized me as a 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 access to *Mercyhealth MyChart* is provided as a convenience to patients and Mercyhealth has the right to end access at any time.
- ⌘ I understand that entries I make may become part of my child's legal medical record.
- ⌘ 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.
- ⌘ I understand that my use of *Mercy MyChart* is voluntary and my proxy access can be revoked by the patient in writing to Mercy Health System.
- ⌘ I understand my revocations will not affect any disclosures that were made prior to processing the revocation.
- ⌘ I understand that additional terms and conditions applicable to my use of *Mercyhealth MyChart* are set forth on the site and I agree to any and all current and future terms and conditions noted on the *Mercyhealth MyChart* site.

By signing below, I acknowledge that I have read and understand this form. I agree to its terms and choose to be designated as a *Mercyhealth MyChart* proxy thereby allowing me access to the patient named above including their health information included in *Mercyhealth MyChart*.

➔ _____

*Signature (Proxy)* *Relationship to patient* *Date (required)*

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# Mercyhealth MyChart Adult Proxy Request Form

**Authorization to access another adult's *Mercyhealth MyChart* record**
To authorize another person's access to my *Mercyhealth MyChart*, please complete this form. This form is valid until revoked by the patient in writing to Mercy Health System. **Please print clearly.**

## Patient's Information (Person authorizing *MyChart* access)

Name of Patient:_____ Date of Birth: ____/____/_____
(*last, first, middle initial*)
Street Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone Number: _____

## Proxy Information (Person requesting access)

Name of Proxy: _____ Date of Birth: ____/____/_____
(*last, first, middle initial*)
Street Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone Number: _____

### Mercyhealth MyChart Terms and Agreement

- I understand that *Mercyhealth MyChart* is intended as a secure online source of medical information and contains a limited amount of medical information from a patient's electronic medical record from all Mercyhealth facilities. It does not reflect the complete contents of the medical record. Access may include information related to behavioral or mental health, developmental disabilities, HIV/AIDS, treatment for substance use disorder, genetic testing and counseling, sexual assault/abuse, child abuse, sexually transmitted illness, pregnancy, birth control and any other information documented in my medical record.
- I understand that access to *Mercyhealth MyChart* is provided as a convenience to patients and Mercyhealth has the right to end access at any time.
- 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.
- I understand that designating a *Mercyhealth MyChart* proxy is voluntary. I am not required to designate a *Mercyhealth MyChart* proxy and I am not required to provide this authorization. I also understand that Mercyhealth does not condition any of my healthcare treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.
- I understand my revocations will not affect any disclosures that were made prior to processing the revocation.
- I understand that additional terms and conditions applicable to my use of *Mercyhealth MyChart* are set forth on the site and I agree to any and all current and future terms and conditions noted on the *Mercyhealth MyChart* site.
- I understand this authorization is valid until I revoke in writing to Mercyhealth. If I revoke this authorization, my designated proxy's access to my *Mercyhealth MyChart* will end.

By signing below, I acknowledge that I have read and understand this form and agree to its terms. I authorize release of my health information. I consent to allow the person named above access to my *Mercyhealth MyChart* account that contains my medical information currently available and that may become available as a result of future medical care.

➔ _____

*Signature (Patient)* *Relationship to proxy* *Date (required)*