Mercyhealth™
A passion for making lives better.™

Adult proxy Request Form

Access to another adult's *Mercy MyChart* record
To request access to the *Mercy MyChart* account of an adult patient whose medical care you help manage, please complete this form. This form is valid until revoked by the patient in writing to Mercy Health System.

Return all forms to: MyChart Support
1236 Barberry Dr
Janesville WI 53546
888-99MYCHART or 888-996-9242
Fax # 608-314-8722

Please print clearly:

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) _____

MyChart terms and agreement

- ⌘ I understand that *Mercy MyChart* is intended as a secure online source of confidential medical information. If I share my *Mercy MyChart* ID and password with another person, that person may be able to view my or my child's health information.
- ⌘ I understand that it is my responsibility to ensure that my e-mail address is current at all times, and that if my e-mail address is not current I will not receive important messages from *Mercy MyChart*.
- ⌘ I understand that *Mercy MyChart* contains selected, limited medical information and that *Mercy MyChart* does not reflect the complete contents of the medical record.
- ⌘ I understand that my activities within *Mercy MyChart* may be tracked electronically and that entries I make may become part of the medical record.
- ⌘ I understand that access to *Mercy MyChart* is provided as a convenience to patients and Mercy Health System has the right to end access to *Mercy MyChart* at any time.
- ⌘ 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 acknowledge that I have read and understand this *Mercy MyChart* adult proxy form. I agree to its terms and choose to be designated as *Mercy MyChart* proxy, thereby allowing me access to the patient named above, and access to their *Mercy MyChart health information.*

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

** Please provide a copy of legal paperwork verifying this information if not already on file.

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Adult proxy Authorization Form

Authorization to access another adult's *Mercy MyChart* record
To authorize another person who helps manage my medical care, access to my *Mercy MyChart*, please complete this form. This form is valid until revoked by the patient in writing to Mercy Health System.

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: _____

MyChart terms and agreement

⌘ I understand that *Mercy MyChart* is intended as a secure online source of medical information containing a limited amount of information obtained from my electronic medical record and may include information from all Mercy Health System facilities. This may include information about mental health, development disabilities, alcohol and/or drug abuse, acquired humane deficiency syndrome (AIDS), HIV test results and/or intoxication tests.

⌘ I understand that access to *Mercy MyChart* is provided as a convenience to patients and *Mercy Health System* has the right to end access to *Mercy MyChart* 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 *Mercy MyChart* proxy is voluntary. I am not required to designate a *Mercy MyChart* proxy and I am not required to provide this authorization. I also understand that Mercy Health System does not condition any of my healthcare treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.

⌘ I understand this authorization is valid until I revoke in writing to Mercy Health System. If I revoke this authorization, my designated proxy's access to my *Mercy MyChart* will end.

⌘ I understand my revocations will not affect any disclosures that were made prior to processing the revocation.

I acknowledge that I have read and understand this *Mercy MyChart* Adult proxy Authorization form. I agree to its terms and choose to designate the person named above as my *Mercy MyChart* proxy, there by allowing them access to my *Mercy MyChart* electronic health information.

➔ _____

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