

MYCHART PROXY ACCESS REQUEST FORM

Completing this form allows someone else ("Proxy") to be able to access portions of the Patient's protected health information maintained by Children's Healthcare of Atlanta, Inc. and/or any of their electronic medical record affiliates (the "Organizations") through MYchart. The Patient (when applicable) and Proxy must agree to and comply with the terms and conditions of the MYchart web page, and this document.

Patient Information:

Name (last, first, middle initial): _____ DOB: ____ - ____ - ____

Patient's GI Doctor: _____

If Patient is 13-17, Patient Email: _____ PIN (any 4 digit combination): ____

Proxy Information: (All Sections required-please print clearly) (If patient is over 18, the patient is the proxy)

Email Address (required): _____ PIN (any 4 digit combination): ____

Name (last, first, middle initial): _____ DOB: ____ - ____ - ____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (____) ____ - ____

Instructions:

✓ For adult to child (age 0-17) proxy access or adult to child (age 13-17) proxy and patient access, complete section A

OR

✓ For adult to adult proxy (patient age 18 or older) access where the patient can understand and make his/her health care decisions, complete section B

Section A

For Adult to Child (age 0-17) Proxy Access

Proxy:

I acknowledge and agree that:

- I have parental rights or legal guardianship rights to access this Patient's record.
- I have not been denied periods of physical placement with the Patient and there are no court orders or restraining orders in effect limiting my access to this Patient's medical records and/or information.
- I will be using my own MYchart account at the Organizations to access the Patient's Mychart account.
- I will comply with the terms and conditions on the MYchart web page and this document.
- I will keep my password confidential and not share this information with anyone.
- If Patient's age 13-17, I agree that Patient may access Patient's own MYchart account.
- Communications on behalf of the Patient through MYchart must be sent from the Patient's record and responses will be received in the Patient record. For child age 0-13, MYchart e-mail alerts will be sent to the e-mail address entered under Proxy Information. For Child age 13-17, MYchart e-mail alerts will be sent to the email addresses provided by both the Proxy and the Patient.

_____/_____/_____/_____
Proxy Signature (required) Relationship to Patient (required) Date (required) Time (required)

Section B

For Adult to Adult (age 18 or older) Proxy Access

Proxy:

I acknowledge and agree that:

- I will be using my own MYchart account at the Organizations to access the Patient's Mychart account.
- I will comply with the terms and conditions on the MYchart web page and this document.
- I will keep my password confidential and not share this information with anyone.
- Communications on behalf of the Patient through MYchart must be sent from the Patient's record and responses will be received in the Patient record. MYchart e-mail alerts will be sent to the e-mail address entered under Proxy Information.

_____/_____/_____/_____
Proxy Signature (required) Relationship to Patient (required) Date (required) Time (required)