For Internal Use Only

Not activated as of: _____

Activated by: _____

Date activated: _____

soundfamily MEDICINE

PATIENT LABEL HERE

MyChart Adult Proxy Form

Access to Another Adult's MyChart Record

To request access to the MyChart Record of an adult whose medical care you help manage, please complete this form. The patient must sign this form and provide authorization for release of medical information in MyChart on the "Adult Proxy Authorization Form". If the patient is not competent to sign on their own behalf, we will require documentation of guardianship or a power of attorney for healthcare decisions.

Please note that if you are a patient at Sound Family Medicine you will need to have an active MyChart account because the patient's MyChart account will be accessed through your (the proxy's) MyChart. If you are not a patient at Sound Family Medicine, we will set up an account for you once this form has been processed.

Return all forms to **any Sound Family Medicine clinic front desk staff** or **Fax to Medical Records: (253) 435-9318.**

Individual requesting access to another adult's MyChart Record:

(Completion of all sections is required)

Name (*last, first, middle initial*): _____

Date of Birth: _____

Street Address: _____ City:_____ State:_____ Zip:_____

E-mail Address: _____ Phone Number: _____

Patient's information:

(Completion of all sections is required)

Name (*last, first, middle initial*): _____

Date of Birth: _____

Street Address: _____ City:_____ State:_____ Zip:_____

E-mail Address: _____ Phone Number: _____

MyChart Terms and Agreement

- I understand that MyChart is intended as a secure online portal for viewing confidential medical information. If I share MyChart ID and password with another person, that person may be able to view health information about someone who has authorized me as a MyChart 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 MyChart contains selected, limited medical information from a patient's medical record and that MyChart does not reflect the complete contents of the medical record. I also understand that the patient may request a copy of his/her medical record from the clinic.
- I understand that my activities within MyChart may be tracked by computer audit and that entries I make may become part of the medical record.

- This form only authorizes access through MyChart and does not authorize release of my medical record to my designated proxy by other methods or in other formats.
- I understand that once information has been disclosed, it potentially may be re-disclosed by my proxy and the disclosed information may not be covered by federal privacy protections.
- I understand that I am not required to designate a MyChart proxy and I am not required to provide this authorization. I also understand that Sound Family Medicine does not condition any of my health care treatment, payment, or other services on whether I provide this authorization. I know that if I do not provide this authorization Sound Family Medicine will not be permitted to provide my designated proxy with access to my MyChart record.
- I understand that access to MyChart is provided by Sound Family Medicine as a convenience to its patients and that Sound Family Medicine has the right to deactivate access to MyChart at any time for any reason. I understand that use of MyChart is voluntary and I am not required to use MyChart or to authorize a MyChart proxy.
- By signing below, I acknowledge that I have read and understand this MyChart Sign-Up form and I agree to its terms.

Your (Proxy) Signature (Required):

Signature: _____

Relationship to patient: _____

Date: _____

I acknowledge that I have read and understand this MyChart Sign-up form. I agree to its terms and choose to designate the person named above as my MyChart Proxy, thereby allowing them access to my MyChart.

This proxy authorization will expire in 90 days if the associated MyChart account is not activated within that time period.

Patient Signature or Authorized Person (Required):

Signature: _____

Relationship to patient: _____

Date: _____