MYCHART PROXY ACCESS REQUEST FORM

ACCESS TO A CHILD, TEEN, OR ADULT MYCHART RECORD

Note to Employees: Completed forms should be scanned into the patient's medical record and then submitted to the IT Department. Proxy access will be established once this form is reviewed and verified. Please ensure all required sections are complete and required identification is validated upon submission (Section 3.3 – 3.4).

A Proxy is a person, like a family member or caregiver, who has been granted the authority to access and act on another individual's health information and make medical decisions. To request access to another Friends of Family Health Center (FOFHC) patient's MyChart patient web portal account, please complete all pages of this Proxy Access Request Form and submit it to your clinic registration staff. Access to the child, teen, or adult's MyChart will be through your own MyChart account. The MyChart patient web portal is at https://mychart.ochin.org/FOFHealthCenter/. To request a paper copy of the patient's chart, contact the Medical Records Department at (562) 690 -0400.

Please select from the following Proxy Access options and follow the instructions:

☐ **Child Proxy –** If the patient is a minor between the ages of 0 – 11, you will be granted full access to the minor patient's MyChart record until the child reaches age 12. **Complete sections 1, 2 and 3 of this form.**

☐ **Teen Proxy –** If the patient is a minor between the ages of 12 – 17, access is limited to parental access that ensures privacy for our patients in accordance with the California Confidentiality of Medical Information Act (CMIA). NOTE: The limitations in place for MyChart Proxy Access do not affect any legal rights or limitations you have to access the patient's records by other means. **Complete sections 1, 2 and 3 of this form.**

☐ **Adult Proxy and Emancipated Minor Proxy –** If the patient is an adult, 18 or older, consent from the patient (or authorized legal guardian) is required for access to the patient's MyChart record. **Complete sections 1, 3 and 4 of this form.**

SECTION 1 (REQUIRED)

Proxy Information: (All items required. Please print clearly.)

Name (last, first, middle initial) _____

Social Security Number (last 4 digits): _____ Date of Birth: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____

Email Address: _____

Relationship to Patient: _____

SECTION 2 (REQUIRED FOR CHILD AND TEEN PROXY)

Please provide the following information for each child. All fields are required. If you have more than four children for whom you would like proxy access, please print another form.

	Child's Name (Last, First, Middle Initial)	SSN (Last 4 digits)	Date of Birth
1			
2			
3			

SECTION 3 (REQUIRED)

USER ACKNOWLEDGEMENT OF TERMS & CONDITIONS FOR USE OF FOFHC MYCHART

You are requesting access to FOFHC MyChart, which contains the online health information for you or another person. By signing below, you represent that you have the legal right to access the information contained in the patient's medical record.

1. If you are a parent or other legally authorized representative of the patient, you certify and represent that no court has terminated your parental or legal rights with respect to the patient or otherwise restricted your access to the patient's information.
2. By using FOFHC MyChart, you affirm your acceptance of FOFHC MyChart's Terms and Conditions and agree to comply with them now and throughout the period of your use of FOFHC MyChart. If you do not agree to the Terms and Conditions, do not proceed to use FOFHC MyChart.
3. **Parents or guardians of children age 0 –11 must submit this form in person. Birth and adoptive parents must present photo identification and sign this form acknowledging that they have a right to the child's health care information. If you are not the birth or adoptive parent of the child, you must present legal paperwork (such as a court order or medical power of attorney) proving you are the legally recognized caregiver for the child.**
4. **If you are an Adult requesting access to another Adult patient's record who does not have decision-making capacity, you must provide a copy of legal conservatorship, a letter from the provider confirming the patient is without decision-making capacity or documentation from the medical record, written by the provider, supporting the patient's inability to make decisions.**
5. You agree that it is your responsibility to select a confidential password, to maintain your password in a secure manner, and to change your password if you believe it may have been compromised in any way.
6. You understand that FOFHC MyChart contains selected, limited medical information from a patient's medical record and that FOFHC MyChart does not reflect the complete contents of the medical record. You also understand that a paper copy of a patient's medical record may be requested from the FOFHC's Medical Record Department.
7. You understand that your activities within FOFHC MyChart may be tracked by computer audit and that entries you make become part of the patient's legal medical record.
8. You understand that access to FOFHC's MyChart is provided by FOFHC as a convenience to its patients and that FOFHC has the right to deactivate access to FOFHC MyChart at any time for any reason. You understand that use of FOFHC MyChart is voluntary, and you are not required to use it or to authorize a MyChart Proxy. FOFHC reserves the right to revoke online access to MyChart at any time.
9. By signing below, you acknowledge that you have read and understand this FOFHC MyChart Proxy Form and you agree to its terms and conditions for use.

Proxy Signature: _____ Date: _____

Printed Name of Proxy: _____ Relationship to Patient: _____

SECTION 4 (REQUIRED FOR ADULT AND EMANCIPATED MINOR PROXY)

Please read carefully: this section is an authorization that will permit FOFHC to release your health information to your designated adult proxy. This form should be completed by the patient who is authorizing another adult to access the health information in his or her FOFHC record. **This authorization expires when you initiate a request to revoke it. You may deactivate access to the adult proxy specified above at any time through FOFHC MyChart or by providing a written request to your primary clinic.**

PATIENT INFORMATION

Name (last, first, middle initial) _____

Social Security Number (last 4 digits): _____ Date of Birth: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____

Email Address: _____

Relationship to Proxy: _____

ADULT OR EMANCIPATED MINOR AUTHORIZATION FOR PROXY ACCESS TO FOFHC MYCHART

I am requesting that (insert name of proxy) _____ receive access to my health information that is available in FOFHC MyChart. This person is my designated MyChart proxy. I authorize FOFHC MyChart to release the health information contained in my FOFHC MyChart record to my MyChart designated proxy. I understand that the medical information in my FOFHC MyChart account is obtained from my electronic health record. I authorize release of this information only through my FOFHC MyChart record. This form does not authorize release of my health 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 the proxy and the disclosed information may not be covered by the same privacy protections.

Participating in FOFHC MyChart and designating a MyChart proxy are completely voluntary. 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 FOFHC MyChart does not condition any of my health care treatment, payment or other services on whether I provide this authorization. However, I also understand that if I do not provide authorization, FOFHC MyChart is not permitted to provide my designated proxy access to my FOFHC MyChart record.

I may cancel this authorization at any time online within my FOFHC MyChart account or by providing a written request for cancellation to my primary clinic. I understand that if I cancel this authorization, my designated proxy's access to my FOFHC MyChart record will end. I also understand my cancellation will not affect any disclosures that were made prior to processing the revocation before my cancellation request is processed.

Patient Signature (or Conservator, if verified): _____ Date: _____

Printed Name of Patient (or Conservator, if verified): _____