Franciscan ALLIANCE

MyChart Proxy Access Informed Consent

Your Information: (All sections required – please print clearly)

Name (*first, middle, last*) _____

Last 4 of Social Security Number: _____ Date of Birth: _____

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

Phone Number: _____

I agree to abide by the guidelines for the MyChart Patient Portal electronic communication, as outlined below. MyChart is not intended for critical or time sensitive communication. I understand that I am to contact the hospital or physician directly for any urgent or emergent situations. My failure to adhere to the following guidelines may result in termination of the MyChart access. When using MyChart I agree to never use MyChart to communicate information related to behavioral/mental health, chemical dependence, such as alcohol and substance abuse or workers' compensation injuries and disabilities.

I understand that the hospital or provider or a designated staff member will maintain certain activities with MyChart as part of the practice medical record, use reasonable and appropriate security practices to protect electronic patient information and prevent unauthorized access (password protection, encryption, proxy authorizations, etc.) and share MyChart communications with hospital or office staff and other healthcare providers as needed.

Proxy Access to MyChart Record

Please provide the following information for each person whose MyChart record you're requesting to access (request another form to list additional names if necessary). Access to proxy records will occur through your MyChart record. For proxy access to MyChart record of patients under the age of 12, page 2 is not required.

Proxy Access to Health Records for children 12 to 18 years old is limited to the following transactions:

- Appointment requests
- Referral requests
- Immunization records
- General advice in follow-up to an initial in office evaluations or consult
- Educational material requests

A. Name *(first, middle, last)*: _____

Last 4 of Social Security Number: _____ Date of Birth: _____

B. Name *(first, middle, last)*: _____

Last 4 of Social Security Number: _____ Date of Birth: _____

C. Name *(first, middle, last)*: _____

Last 4 of Social Security Number: _____ Date of Birth: _____

I understand that e-mail is not a confidential means of communication. I agree to waive any rights that I may have against Franciscan Alliance, any affiliated organization, or physician, or the supplier or operator of MyChart, for any loss of information due to technical failures and/or unintended breach of confidentiality, due to unauthorized access to my information, as a result of my decision to communicate with my physician in this manner. I hereby request access to MyChart and understand that in order to gain access to MyChart I will be given a confidential password. I agree to keep it confidential and not share it with anyone else. I understand that my use of MyChart is subject to certain terms and conditions. I agree to review MyChart terms and conditions before accessing MyChart and further agree that by accessing MyChart I am agreeing to abide by the MyChart terms and conditions.

I have read all of the above, asked questions, and received answers concerning areas I did not understand. I agree that if the minor becomes eligible to consent on his or her own behalf that I will notify Franciscan Alliance, and I will not be entitled to proxy access unless a subsequent consent form is signed by such minor.

_____ _____

Signature of Patient/Authorized Person* **Date** *(Required)*

*If authorized person signs, indicate authority (e.g. guardian) and attach documentation

Internal use only: request processed by _____

MyChart Proxy Release of Information
To be completed by the Patient

This form is acknowledgment and approval that will permit Franciscan Alliance, Inc. **("**Franciscan Alliance**")** to release your medical information to your designated proxy. Please read it carefully.

This form should be completed by the patient (age 12 and over) acknowledging and approving proxy access to medical information in his or her MyChart record. It must accompany the MyChart Proxy Access Informed Consent form which provides the name and information of the individual who the patient is acknowledging and approving access to his or her MyChart record as a proxy.

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

Last 4 digits of Social Security Number: _____ Date of Birth: _____

I am requesting that _____ *(insert name of proxy)* receive access to my health information that is available in my Franciscan Alliance MyChart Record. This person is my designated MyChart proxy. I acknowledge Franciscan Alliance will release the health information contained in my MyChart record to my MyChart proxy. I understand that the medical information in MyChart is obtained from my electronic medical record and may include information from all facilities listed in Franciscan Alliance's Notice of Privacy Practices. I approve of release of any information contained in my MyChart medical record held by Franciscan Alliance to my designated proxy.

I approve of release of this information only through my MyChart record. This form does not permit release of my medical record to my designated proxy by other methods or in other forms.

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.

Participation in MyChart and designating a MyChart proxy is completely voluntary. I understand that I am not required to designate a MyChart proxy and I am not required to provide this acknowledgement and approval. I also understand that Franciscan Alliance does not condition any of my health care treatment, payment or other services on whether I provide this acknowledgement or approval. However, I also understand that if I do not provide acknowledgement and approval Franciscan Alliance is not permitted to provide access to my MyChart record to my designated proxy.

For minors ages 12 to 18 this acknowledgement and approval expires on my eighteenth birthday or my written notice to Franciscan Alliance that I have obtained the right to consent on my own behalf.

Date: _____

Signature of Patient (or authorized person*): _____

Printed Name: _____

***If person other than the patient signs, indicate authority to sign for patient (e.g., guardian) and attach documentation**