



## ACCESS TO ANOTHER ADULT'S MyChart® RECORD (Authorizing a Proxy)

**Instructions:** This form should be completed by the patient and by the adult the patient is authorizing to access medical information in his or her MyChart record. The authorized adult will be referred to as the patient's proxy. Please complete the second page of this form and return it to any of the addresses shown below. Please note that the patient's chart will be accessed through the proxy's MyChart record. Completing this form will establish a MyChart record for the patient and their proxy.

### **Return forms to:**

- Cone Health, Department of Health Information Management, 1200 N. Elm St. Greensboro, NC 27401
- Email forms to: conehealthmychart@conehealth.com
- Present signed form at your Cone Health provider location.
- We will email an activation code to the email address you provide below. Use the activation code to set up your MyChart account and to have access to another adult's account.

### **MyChart Terms and Agreement:**

- I understand that MyChart is intended as a secure online source of confidential medical information. If I share my MyChart ID and password with another person, that person may be able to view the patient's personal health information.
- 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 a paper or electronic copy of a patient's medical record may be requested from the patient's clinic.
- I understand that the activities within MyChart may be tracked by computer audit and that entries I make may become part of the patient's medical record.
- I understand that access to MyChart is provided by Cone Health as a convenience to its patients and that Cone Health 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.
- I understand that the medical information in MyChart is obtained from my electronic medical record and may include information from all facilities listed in Cone Health's Notice of Privacy Practices.
- I understand that I am authorizing release of any information contained in my MyChart medical record held by Cone Health to my designated proxy. This may include information pertinent to drug/alcohol use and sexually transmitted infections such as HIV/AIDS.
- I authorize release of this information only through my MyChart record. This form does not authorize 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 authorization.
- I also understand that Cone Health 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, Cone Health is not permitted to provide access to my MyChart record to my designated proxy.
- I may revoke this authorization at any time by providing a written request for revocation to Cone Health. I understand that if I revoke this authorization, my designated proxy's access to MyChart record will be ended. I also understand my revocation will not affect any disclosures that were made prior to processing the revocation request
- If the patient has diminished capacity and cannot sign the form, you will be required to obtain physician certification.



# AUTHORIZATION FOR ACCESS TO MyChart® ACCOUNT

## TO BE COMPLETED BY THE AUTHORIZED ADULT (PROXY)

*All fields are required. Please print clearly.*

Proxy's name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Last 4 digits of SSN: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Proxy's email address (**required**): \_\_\_\_\_

Have you ever been a Cone Health patient?  Yes  No

*By signing below, I acknowledge that I have read and understand this MyChart access form and agree to its terms.*

\_\_\_\_\_  
Proxy Signature

\_\_\_\_\_  
Date

Relationship to patient (Note: When required by law, proof of parentage, guardianship, or power of attorney may be needed in order to process your request.)

## PATIENT INFORMATION

*All fields are required. Please print clearly.*

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Last 4 digits of SSN: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Patient email address (**required**): \_\_\_\_\_

*I acknowledge that I have read and understand this MyChart access form. I agree to its terms and choose to designate the person named above as my MyChart proxy, thereby allowing them to access my MyChart medical record.*

\_\_\_\_\_  
Signature of patient or authorized representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient (if applicable)

## Physician Certification (If Applicable)

*All fields are required.*

I certify that this patient is affected by a condition that prevents them from being able to appreciate and understand what they are signing.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Physician/Practitioner

\_\_\_\_\_  
Phone Number

**You may deactivate access of the adult proxy specified above at any time through MyChart or by providing a written request to Cone Health.**

### For Cone Health use only:

Processed date: \_\_\_\_\_ Patient MRN: \_\_\_\_\_

Name of staff member (please print) \_\_\_\_\_

*MyChart is a registered trademark of Epic Corporation.*

