Adult Proxy Request and Authorization Form

For Access to MyChart™ Patient Portal

This form is an authorization used to designate another adult as my MyChart proxy and give them access to health information available in my University Health MyChart account.

Please read carefully.

Section I. Patient Information (All sections required – PLEASE PRINT.)

Name:______________________________ **DOB:**____/____/________
Last First MI MM DD YYYY

Home Address:______________________________
Street Address City State Zip Code

Phone #:____________________ ❑Cell ❑Home ❑Work **Email:** ____________________

Section II. Proxy's Information (PLEASE PRINT.)

Name:______________________________ **DOB:**____/____/________
Last First MI MM DD YYYY

Home Address:______________________________
Street Address City State Zip Code

Phone #:____________________ ❑Cell ❑Home ❑Work **Email:** ____________________

MyChart Username: ____________________

By signing this Proxy Request and Authorization Form, I acknowledge and agree that:

- Participation in MyChart and designating a MyChart proxy is entirely voluntary. I understand that I am not required to appoint a MyChart proxy, and I am not required to provide this authorization. I also understand that University Health does not condition any of my health care treatment, payment, or other services on whether I give this authorization. However, I also understand that if I do not provide authorization, University Health cannot provide my designated proxy access to my MyChart record.
- I understand that the medical information in MyChart is obtained from my electronic medical record and may include information from all University Health facilities. This may include material relating to 1) Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) infection, 2) treatment for drug or alcohol abuse or 3) mental or behavioral health or psychiatric care.
- I authorize the release of information through my MyChart account only. This form does not authorize the release of my medical record by any other methods or formats.
- I understand that any information obtained from my account may be potentially re-disclosed by the proxy, and federal privacy protections may not cover such disclosures.
- This authorization will remain active unless revoked in writing utilizing University Health form BC#236 "Request for Restrictions on Use/ Disclosure of Protected Health Information". I understand that revoking this authorization will end my designated proxy's access to my MyChart account. I also understand my revocation will not affect any disclosures made before the processing of the revocation request.

______________________________ / ______________________________ / ____________
Signature of Patient (or authorized person) **Relationship to Patient** **Date** (required)

If you have any questions or need help completing this form, please contact the office below:

Medical Records Department
701 S. Zarzamora
San Antonio, TX 78207
Phone: (210)358-1777 FAX: (210)702-4088

Office Use Only:
Patient's MRN____________ ❑ **Approved: Activation Link sent on:**________ ❑ **Rejected: Reason:** ____________

TO BE PLACED IN THE MEDICAL RECORD