THE UNIVERSITY OF KANSAS HEALTH SYSTEM 11300 Corporate Ave., Suite 345, Lenexa, KS 66219 Health Information Management Dept.	**Do not write in this box** DT4171 MyChart Access Request	**Name:**_____ **DOB:** _____ **MRN:**_____

MyChart Proxy Access Request–For Access to an Adult Patient's MyChart

Giving Others Access to Your Medical Information in MyChart

- A proxy is a person who can access your MyChart account information as if they were you.
- A spouse, adult caregiver, parent, or legal guardian may be granted full access to your MyChart account with proxy access.
- In order for an adult proxy (18 or over) to view information in MyChart the below form needs completed.
- Authorization for proxy access to an adult patient's account is valid until revoked by the patient, death, or any statutory or regulatory requirement automatically allows the authorization to expire.
- Adults with diminished capacity, may have their legal guardians request proxy access.

1. Adult Patient information: (Patient to which proxy access is requested)

Patient Name: Last_____ First_____ Birthdate (mm/dd/yyyy) _____ Gender M___ F___

Middle Name _____Previous Names _____Social Security #: _____ -_____ -_____

Address_____City_____State_____Zip_____

Primary Cell Phone _____ Email _____

Primary Physician _____Primary Practice or Clinic _____

2. Adult Proxy information: (Parent, spouse, or legal guardian wishing to access patient information by proxy)

Proxy Name: Last_____ First_____ Birthdate (mm/dd/yyyy) _____ Gender M___ F___

Address_____City_____State_____Zip_____

Previous Names_____ Social Security #: _____ -_____ -_____

Primary Phone _____ Alternate Phone_____ Email_____

Does the proxy have an active MyChart account? _____ Has the proxy been a patient of a KU Health System? _____

Relationship to patient: ____ Parent ____ Spouse ____ Caregiver for Adult Patient ____ Legal Guardian *____ Other*

(specify)_____

**This request must be accompanied by a copy of legal documentation verifying the relationship of the proxy to the patient.*

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

To be completed by the adult patient.

I authorize The University of Kansas Health System to release medical information via MyChart to: The Designated Proxy named above

- **The following information is to be released:** All information as allowed through MyChart (Note that MyChart may not contain the complete medical record.)
- I understand that I have a right to limit this authorization at any time through MyChart Family Access Settings or by signing the MyChart Proxy Revocation form.
- I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I authorize the release of these records.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.
- I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact The University of Kansas Health System Office of Patient Relations at 913-588-1290.
- I understand this authorization must be filled out completely and signed and dated in order to be considered valid. The activation code I receive will be valid for sixty days.
- I represent that I am 18 years of age or older, or legally emancipated, and have the legal authority to sign this authorization.

_____ _____ ____/____/____

Signature of Patient or Personal Representative | Printed Name of Patient or Personal Representative | Date

Mail, Fax, or Email completed form and required documentation to: The University of Kansas Health System-Health Information Management Dept.
11300 Corporate Ave., Suite 345, Lenexa, KS 66219 Fax: 913-588-2495 Email: MyChart@kumc.edu

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