myChart
Saint Francis Health System

ADULT PROXY REQUEST

915-001A front / 07-17

Saint Francis Hospital
Saint Francis Hospital South
Laureate Psychiatric Clinic and Hospital
Warren Clinic

Access to Another Adult's MyChart Record

To request proxy access to the MyChart record of an adult, please complete this form. The patient or their legal representative must sign this form and provide authorization for release of medical information in MyChart on the "Authorization for Release of Medical Information to Adult Proxy." Please note that the patient's chart will be accessed through your (the proxy's) MyChart record. Completing this form will establish a MyChart record for you and for the patient. Please provide a government-issued ID for identity verification when submitting this form. *Attach a copy of guardianship papers, power of attorney or Advance Directive of patient.*

Return forms to your Warren Clinic provider or Saint Francis health care provider. If you don't have a Saint Francis provider, please submit to: Saint Francis Health Information Department, Release of Information, 6161 South Yale Avenue, Tulsa, Oklahoma 74136.

YOUR PROXY INFORMATION (All Sections Required ~ Please Print Clearly)
This section should be completed by the individual requesting access to another adult's MyChart record.

NAME - *LAST, FIRST, MIDDLE INITIAL* ☐ M ☐ F	DATE OF BIRTH	LAST 4 NUMBERS OF SSN

STREET ADDRESS	CITY	COUNTY	STATE	ZIP CODE	COUNTRY

PHONE NUMBER	CHECK ONE ☐ Mobile ☐ Home ☐ Work	EMAIL ADDRESS	SAINT FRANCIS HEALTH SYSTEM PATIENT ☐ Yes ☐ No

PATIENT'S INFORMATION (All Sections Required ~ Please Print Clearly)
Complete this section with information about the patient whose MyChart record you're requesting to access.

NAME - *LAST, FIRST, MIDDLE INITIAL* ☐ M ☐ F	DATE OF BIRTH	LAST 4 NUMBERS OF SSN

STREET ADDRESS	CITY	COUNTY	STATE	ZIP CODE	COUNTRY

PHONE NUMBER	CHECK ONE ☐ Mobile ☐ Home ☐ Work	EMAIL ADDRESS	SAINT FRANCIS HEALTH SYSTEM PATIENT ☐ Yes ☐ No

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 health information about someone who has authorized me as a MyChart proxy.
- 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 understand that my 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 Saint Francis Health System as a convenience to its patients and that Saint Francis Health System 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.
- If the proxy's legal relationship with the patient changes, Saint Francis Health System must be informed immediately by sending written notice to your Saint Francis health care provider.

By signing below, I acknowledge that I have read and understand this MyChart sign-up document and the attached Terms and Conditions, and attest that I am the authorized proxy of the patient.

YOUR (PROXY) SIGNATURE	DATE	TIME

PRINTED NAME	RELATIONSHIP TO PATIENT

I acknowledge that I have read and understand this MyChart sign-up document. I agree to its terms and choose to designate the person named above as my MyChart Proxy, thereby allowing them access to my MyChart Medical Record.

PATIENT SIGNATURE (OR AUTHORIZED PERSON)	DATE	TIME

PRINTED NAME	RELATIONSHIP TO PATIENT

myChart
Saint Francis Health System

ADULT PROXY REQUEST

915-001A back / 07-17

Saint Francis Hospital
Saint Francis Hospital South
Laureate Psychiatric Clinic and Hospital
Warren Clinic

Authorization for Release of Medical Information to Adult Proxy

This form is an authorization that will permit Saint Francis Health System to release your medical information to your designated adult proxy. Please read it carefully.

This form should be completed by the patient who is authorizing another adult to access medical information in his or her MyChart record. It must accompany the Adult Proxy Form, which provides the name and information of the individual who the patient is authorizing to access their MyChart record as a proxy.

NAME - *LAST, FIRST, MIDDLE INITIAL*	☐ M ☐ F	DATE OF BIRTH

I am requesting that _____*(insert name of proxy)* receive access to my health information that is available in my Saint Francis Health System MyChart Record. This person is my designated MyChart proxy. I authorize Saint Francis Health System to 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 other Saint Francis Health System facilities. I authorize release of any information contained in my MyChart medical record held by Saint Francis Health System to my designated proxy.

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 Saint Francis Health System 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, Saint Francis Health System is not permitted to provide access to my MyChart record to my designated proxy.

This authorization will expire upon revocation, or on the date or event specified here _____ . I also may revoke this authorization at any time by providing a written request for revocation to Saint Francis Health System. I understand that if I revoke this authorization, my designated proxy's access to my MyChart record will be ended. I also understand my revocation will not affect any disclosures that were made prior to processing the revocation request.

PATIENT SIGNATURE (OR AUTHORIZED PERSON)	DATE	TIME

PRINTED NAME	RELATIONSHIP TO PATIENT

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

FOR SAINT FRANCIS HEALTH SYSTEM USE ONLY

Signature Verification:

☐ Verified by ID (Driver's License, State ID, Military ID) ☐ Form signed in person ☐ Signature on file

SIGNATURE VERIFIED BY	DATE	TIME

Send to Health Information Management Department for final verification and granting of proxy access.