HackensackUMC
Where medicine meets innovation

MyChart Adult Proxy Form

Authorization Granting Access To MyChart Medical Record

You are requesting access to the MyChart record of an adult patient. A person who is granted access to another adult's medical record is called a "Proxy." In order to become a proxy, both the Proxy and the patient must sign this form. In addition, the patient must sign a separate authorization for release of medical information to the Proxy (called the "Adult Proxy Authorization Form.")

Please note that portions of the patient's chart will be accessed through your (the Proxy's) MyChart record. Completing this form will establish a MyChart record for you (if you currently do not have a MyChart account) and for the patient.

You must include two forms of identification*, for both yourself and the patient, one of which must be a government issued photo ID and an additional one that is proof of your current address.

Return all forms to: **Hackensack University Medical Center, Health Information Department, 30 Prospect Avenue, Hackensack, NJ 07601** OR **Fax: 201-489-0591**

Person Seeking Access / Proxy (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*): _____ Date of Birth: _____

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

Email Address: _____ Home Phone Number: _____

Have you received any services at Hackensack University Medical Center? ___YES ___NO

Patient (All sections required – please print clearly)

Complete this section with information about the patient whose MyChart record the Proxy is requesting access.

Name (*last, first, middle initial*): _____ Date of Birth: _____

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

Email Address: _____ Home Phone Number: _____

MyChart Terms and Agreement

- I understand that MyChart is intended to provide limited access to confidential medical information. If I share or allow my MyChart ID and password to be disclosed to another person, that person may be able to view my health information, and information about someone who has authorized me as a MyChart proxy and transmit that information to a third party.
- 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 copy of a patient's medical record may be requested from the Health Information Department of Hackensack University Medical Center at 551-996-2074.
- I understand that access to MyChart is provided by Hackensack University Medical Center as a convenience to its patients and that Hackensack University Medical Center 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 while Hackensack University Medical Center will use reasonable security efforts, no system can guard against all risks of intentional intrusion or inadvertent disclosure medical information on MyChart. MyChart transmits medical information over the internet, a medium that is beyond the control of Hackensack University Medical Center and its contractors. I HEREBY EXPRESSLY ASSUME THE SOLE RISK OF ANY UNAUTHORIZED DISCLOSURE OR INTENTIONAL INTRUSION, OR OF ANY DELAY, FAILURE, INTERRUPTION OR CORRUPTION OF DATA OR OTHER INFORMATION TRANSMITTED IN CONNECTION WITH THE USE OF THIS SERVICE.
- MyChart allows patients and proxies the ability to use confidential messaging. You can elect to message a physician and prevent others from viewing the correspondence.
- You should not make any decision relating to your health based upon the information available in MyChart and/or in your medical record. You always should consult with your physician for health related matters.
- **I have read, understand and agree to the terms and conditions set forth on this page, as well as the terms and conditions included on the webpage used to access MyChart -** www.hackensackumc.org/mychart**.**

▶ _____

Proxy Signature (*Required*) **Relationship to Patient** **Date**

▶ _____

Patient (or authorized person) Signature (*Required*) **Relationship to Proxy** **Date**

HackensackUMC
Where medicine meets innovation

MyChart

Adult Proxy Authorization Form

This form is an authorization that will permit Hackensack University Medical Center to release your medical information to your designated adult proxy. Please read it carefully.

This form must be completed by the patient who is authorizing another adult to access medical information in the patient's MyChart record. It must accompany a fully completed 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. If you do not have an Adult Proxy Form, please contact the Health Information Department of Hackensack University Medical Center at 551-996-2074.

Patient Name (*last, first, middle initial*): _____ Date of Birth: _____

I request that _____ (insert name of proxy) be provided access to my health information that is available in my Hackensack University Medical Center. MyChart Record. This person is my designated MyChart proxy. I authorize Hackensack University Medical Center and its contractors 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 facilities. I authorize release of all information contained in my MyChart medical record held by Hackensack University Medical Center 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 to a third party and the disclosed information may not be covered by legal privacy protections.

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), infection with Human Immunodeficiency Virus (HIV), behavioral or mental health services, and/or treatment for alcohol or drug abuse.

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 Hackensack University Medical Center 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, Hackensack University Medical Center 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 Health Information Department of Hackensack University Medical Center or through my MyChart account. 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.

Date: _____

Signature of Patient (or authorized person): _____

Printed Name: _____

Date of Birth:_____ Home Address:_____

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

_____

NOTE: You may revoke the access of the adult proxy specified above at any time through MyChart or by providing a written request to the Health Information Department of Hackensack University Medical Center.

***Examples of ID:**

1. Government issued photo ID (e.g. driver's license, passport, non-driver ID)
2. Proof of address (e.g. utility or other bill with your name and address, credit card / bank statement with your name and address (no more than 90 days old), birth certificate, marriage license or civil certificate, parent / guardian court papers, government correspondence with your name and address, school transcript with your name and address (no more than two years old)

For office use only: Received by: _____ Department: _____