To allow another adult to view your MyChart, please review this important information <u>before</u> submitting the proxy sign-up form:

1. You must be at least 18 years of age to request that another adult be allowed to view your account (this is called **proxy access**).
2. Your proxy will view your MyChart through his/her own MyChart account. If your proxy does not currently have a MyChart account, and is a UR patient (i.e., he/she sees doctors affiliated with Strong, Highland or UR), then he/she must first **<u>establish a MyChart account before we can fulfill your proxy request.</u>**
3. Your proxy can sign up for MyChart in the following ways:
   - Phone or visit his/her UR doctor's office to sign up at an upcoming appointment.
   - Submit a request for a MyChart account by visiting mychart.urmc.rochester.edu, and click on "**Access for Kids/Family**."

If your proxy is **NOT** a UR patient, then we will establish a MyChart account for him/her.

Thank you for your understanding and cooperation in this matter.

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UR Medicine MyChart Proxy Authorization: 18 and Over

Please read this form carefully before signing. This authorization will permit care provided by this facility or by my treating professionals to release portions of your electronic medical information to the person listed on page 2 of this form.

- **Type of Information to be Disclosed:** I understand that this authorization may cover disclosure of information relating to **ALCOHOL or DRUG ABUSE, PREGNANCY, SEXUALLY TRANSMITTED DISEASES, GENETIC TESTING, PSYCHIATRIC CARE** and/or **CONFIDENTIAL HIV* RELATED INFORMATION**. In the event the medical information described below includes any of these types of information, I specifically authorize release of such information to the person named below. *(*Human Immunodeficiency Virus that causes AIDS)*
- **Method of Disclosure:** My medical information will be disclosed to the person listed below through MyChart.
- **Redisclosure:** I understand that if I authorize the release of HIV related information, the recipient is prohibited from redisclosing such information without my authorization, unless permitted to do so under federal or state law. I understand that I have a right to request a list of people who may receive or use my HIV related information without authorization. If I experience discrimination because of the release or disclosure of HIV related information, I may contact the **NY State Division of Human Rights at 1-800-523-2437** or the **NY City Commission of Human Rights at (212) 306-7500**. These agencies are responsible for protecting my rights. I understand that once my information is released pursuant to this Authorization, it could be redisclosed to others and would no longer be protected by federal privacy regulations.
- **Expiration:** This authorization for release of information will expire only upon my revocation or when the hospital is notified of my death or the death of the person I have authorized to access MyChart.
- **Submitting your Proxy Form:** Give this form to your **Doctor's Office** or **Fax form to UR Medicine Customer Service: (585) 426-8058**. Allow at least 2 weeks for processing; you will receive a message once the proxy form has been processed.
- **Revocation:** I can change my mind and revoke this authorization at any time, except to the extent that anyone has already taken action based on this authorization. I can revoke my authorization online through MyChart, or I can send a written request to: Health Information Management Dept, ATTN: Release of Information, 601 Elmwood Avenue, Box 616, Rochester, NY 14642. I understand that care provided by this facility or by my treating professionals can also revoke access to MyChart (for patients or proxies) at any time and for any reason.
- **Legal Guardianship:** If you are a legal guardian of patient, please include a copy of legal guardianship paperwork.

Please make sure to complete page (2) of this document.

Authorization for Access: I, or my legal representative, request that medical information regarding my past, present and future care and treatment at provided by this facility or by my treating professionals be released through online access to MyChart to the person named below.

▶**PATIENT Information:** (All sections required — please print clearly)

Name: *(Last)* _____ *(First)* _____ *(Middle Initial)*_____

Date of Birth *(MM/DD/YY)*: ____/____/____ Patient Medical Record#:_____

Street Address:_____

City: _____State: _____ Zip:_____

Name of UR Medicine Physician: _____

▶**PROXY Information (the Person you would like to have access to your MyChart):**

Name: *(Last)* _____ *(First)* _____ *(Middle Initial)*_____

Date of Birth *(MM/DD/YY)*: ____/____/____ Phone#:(_____) _____

E-mail (needed if proxy MyChart inactive):_____

Relationship to Patient: _____

Street Address:_____

City: _____State: _____ Zip:_____

▶**Access Level (choose ONE):** ☐ Full Access (recommend) or ☐ Full Access without Notes*
or ☐ Full Access with Billing**

▶**Reason for Release of Information:** Access to MyChart

▶**Information to be Released:** MyChart (Electronic Health Record)

Information may include: *Pregnancy, STD Treatment, Reproductive Health Care, Alcohol/Drug Abuse Treatment,*

My questions about this form have been answered. By signing this form, I also agree to the Terms and Conditions for use of MyChart, which can be found on the MyChart website. I know that I do not have to allow release of medical information, and I will still receive care provided by this facility or by my treating professionals.

▶Signature of Patient or Authorized Representative: *(required)* ▶Date:

▶If signed by **Authorized Representative**, Print Name: ▶Relationship to Patient:

**Your proxy will be unable to view any Visit Notes made by your providers. By referring to these notes, you can gain a better understanding of your health, take more active steps to improve your health and build a closer relationship with your care team. **Your proxy will be able to view your statements, guarantor information, and pay bills through MyChart .*