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 "**Request Access for Myself and Others**."
   - Contact our MyChart Customer Service Center
     8 a.m. to 5 p.m. weekdays: 585-275-URMC (8762), 1-888-661-6162,
     CallCenter@urmc.rochester.edu.

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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Strong Memorial Hospital
Highland Hospital

MyChart Proxy Authorization: 18 and Over

Please read this form carefully before signing. This authorization will permit Strong Memorial/ Highland Hospitals and their doctors and clinics 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.
- **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: **SMH Health Information Management Dept**, **ATTN: Release of Information, 601 Elmwood Avenue, Box 616, Rochester, NY 14642.** I understand that Strong, Highland and my doctors can also revoke access to MyChart (for patients or proxies) at any time and for any reason.
- **Submitting your Proxy Form:** Give this form to your **Doctor's Office** or send the form to the **UR MyChart Customer Service Center, Box 278796, Rochester, NY 14627. Fax Number: (585) 426-8058**. Allow at least 2 weeks for processing; you will receive a message once the proxy form has been processed.

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 Strong Memorial/Highland Hospitals, their doctors and clinics, 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/Strong/Highland 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#:(_____) _____

Relationship to Patient: _____

Street Address: _____

City: _____ State: _____ Zip:_____

▶**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, Genetic Testing, Mental Health or HIV-related information.*

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 from Strong, Highland and their doctors.

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

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

▶Please refer to page (1) for directions on "Submitting your Proxy Form." Note, your proxy will access your medical information through his/her MyChart record. If your proxy does not currently have a MyChart record, we will need him/her to establish one before we can process this form and allow access to your medical information.