St. Charles HEALTH SYSTEM

MYCHART - ACCESS AUTHORIZATION WITH ADULT PROXY

for SCHS Patients and it's Community Connect Affiliates

Patient Information

All fields are required.

Patient Name: ______________________________ DOB: ______________

Address: ______________________________ Email Address: ______________

City, State, Zip: ______________________________ Phone Number: ______________

Proxy Information

All fields are required.

Proxy / Guardian Name: ______________________________ DOB: ______________

Address: ______________________________ Email Address: ______________

City, State, Zip: ______________________________ Phone Number: ______________

Relationship to Patient: ______________________

MyChart Terms and Conditions

I understand the following:

- MyChart contains selected, limited medical information from a patient's medical record and does not reflect the complete contents of the medical record. A paper copy or PDF of a patient's medical record may be requested from the patient's health care provider.
- My activities within MyChart are tracked by computer audit, and entries I make can become part of my medical record or the above-named patient's medical record.
- I understand that my access to any information about the patient may be revoked by the patient through a written request.
- I agree to abide by the St. Charles Health System MyChart Terms and Conditions.
- **Send form to:** SCHS HIM Manager, at 2500 NE Neff Road, Bend, OR 97701

By signing below, I acknowledge that I am providing documentation of my authorization to access the protected health information of the patient described above. I certify that I am legally authorized to access such information about the patient named above, and that the information I have provided is true and correct.

Proxy Signature: ______________________________ Date: ______________

Proxy Printed Name: ______________________________

I acknowledge that I have read and understand this MyChart adult proxy form. I agree to its terms and designate the person named above as my MyChart proxy, thereby allowing him/her access to my MyChart medical record.

Patient Signature: ______________________________ Date: ______________

Patient Printed Name: ______________________________

For Office Use Only

Document to be retained in Patient Record

Patient MRN: ______________________________ Proxy Activation Date: ______________