Medical Record No.
Patient Name
Birthdate
Physician
Please align patient label to the right

Adult Proxy Form

Adult Proxy Access to the Online MyChart of a patient Age 18 or older

Requirements and Procedures

Proxy access for adult patients allows another person, of the patient's choosing, to log into their personal MyChart account, and then connect to information regarding the patient. Patients over 18 will be required to sign the Adult Proxy form granting permission for the Delegate to access their medical record. Both the patient and the Delegate must sign and return the Adult Proxy Authorization Form prior to access being granted.

Requirements for Proxy online access to a patient's record:

- Individual requesting access must have a signed consent from the patient
- Adult Proxy Access Authorization Form must be completed and signed
- Each Delegate requesting access must have their own MyChart account

I understand that:

- I must have a MyChart account
- I must log in to MyChart with my own User ID & Password
- I must click on 'My Family's Records' to access a patient's online record
- I agree to abide by the terms and conditions on the MyChart site
- **MyChart is not to be used in an emergency**

Adult Proxy access to a patient's record will be revoked upon the patient's written request. Ann & Robert H. Lurie Children's Hospital of Chicago and/or your independent physician practice reserves the right to revoke online access to medical information at any time.

Communications.on behalf of the patient must be sent from the patient's record; responses will be posted in the patient's record. MyChart e-mail alerts will be sent to the e-mail address entered in the patient's record.

If you already have a MyChart account, you will receive a letter notifying you that access to the patient's record is available, typically 5-7 business days. You will be granted access only after the completed Adult Proxy Authorization form is received.

If you do not have a MyChart account, upon submitting your electronic request a MyChart Activation Letter with Access Code and instructions will be mailed to you typically in 5-7 business day. Access to MyChart will be granted upon Lurie Children's or your independent physician practice receiving the completed Parent/Guardian Authorization form. If you do not activate your account within 60 days after receiving your MyChart Activation Letter, your account will be inactivated.

Medical Record No.
Patient Name
Birthdate
Physician
Please align patient label to the right

Adult Proxy Authorization Form

Please enter Patient's information below:

Patient's Name: ________________________ Date of Birth: ________________

Address: ________________________ Gender: ________ Male ________ Female

____

To be notified when new messages about the patient's care are sent to **MyChart,** please list an **email** address: ________________________

Please enter Delegate information below:

Delegate Name: ________________________ Date of Birth: ________________

Address: ________________________ Gender:, ________ Male ________ Female

____

Relationship to patient: ______Parent _____Spouse ______Other
If Other, please specify:________________________
Do you have an active MyChart account? _____Yes _____ No

I have read and understand the requirements and procedures regarding accessing a patient's medical record information online as provided on the document titled Adult **Proxy** Access to the Online Medical Record of a MyChart Patient.

I certify that I am a Delegate of the above named patient and all information I have provided is correct. I hereby request access to this patient's online medical record.

________________ ________________________
Date Delegate Signature

I agree to allow the delegate, named above, online access to my medical information currently'available and that may become available as a result of future medical care. I understand I may revoke this access at any time.

I understand that the following items may be disclosed along with other health information in my medical record: HIV/AIDS related health information and/or records, behavioral or mental health information and/or records, information about sexually transmitted disease (STD), pregnancy, birth control, drugs/alcohol diagnosis, treatment, and/or referral information, genetic testing information and/or records, information about sexual assault/abuse, information about child abuse and neglect, and domestic abuse of an adult with a disability.

________________ ________________________
Date Patient Signature

________________ ________________________
Date Witness Signature

Please send this completed form via postal mail or far to your child's primary clinic location.

Milestone Pediatrics
4043 Route 59
Naperville, IL 60564
Fax: 630-420-8957

Form 5237 Revised 10116 HIM Approved 5111