PROHEALTH CARE
MYCHART

# MyChart Proxy Authorization Release of Information Form

ProHealth Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-262-928-4465 (VRS: 1-866-327-8877).
ATENCIÓN: Si habla español, enemos a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-262-928-4465 (VRS: 1-866-327-8877).
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-262-928-4465 (VRS: 1-866-327-8877).

This form is an authorization that will permit ProHealth Waukesha Memorial Hospital, ProHealth Waukesha Memorial Hospital - Mukwonago, ProHealth Oconomowoc Memorial Hospital, their affiliated clinics and other providers who use the ProHealth Care electronic medical record system to release your medical information to your designated proxy. While ProHealth Care has taken efforts to remove sensitive information from MyChart, there may be sensitive information available in MyChart. This means my proxy will have access to records that may include information relating to the diagnosis and/or treatment of mental illness, substance use, sexually transmitted disease, HIV test results, adolescent health, developmental disabilities and genetic testing.

Please complete form AD-33 MyChart Proxy Access Sign-up Form for adult or teen access.

| **Patient Information** (all fields are required) | |
|---|---|
| **Patient Name:** | **Date Of Birth:** |
| **Address:** | **Email Address:** |
| **City, State, Zip:** | **Phone Number:** |
| **Proxy Information** (all fields are required) | |
| **Proxy Name:** | **Date Of Birth:** |
| **Address:** | **Email Address:** |
| **City, State, Zip:** | **Phone Number:** |
| **Relationship to Patient:** | |

**Electronic Protected Health Information in ProHealth Care's MyChart**

| | | | |
|---|---|---|---|
| Secured Messaging | Appointments | Test Results | Medications |
| Allergies | Immunizations | Preventive Care | Medical History |
| Hospital Admissions | Track My Health | Billing & Insurance | My Account Letters |
| Diagnosis | Current Health Issues | After Visit Summary | Upcoming Tests and Procedures |
| Plan of Care | Provider Notes | | |

**MyChart Terms and Conditions for Granting/Receiving Proxy Access:**

- I understand that this authorization permits access to the complete contents of MyChart record provided prior to the date of the authorization as well as any billing information, care and treatment provided while the authorization is valid.
- I understand that this authorization permits my Proxy to schedule visits for me through MyChart.
- I understand that health information disclosed under this authorization to my proxy via the ProHealth Care MyChart patient portal may be subject to re-disclosure by the recipient and is no longer protected by state or federal law.
- I understand that I have a right to revoke this authorization and terminate the proxy connection for the individual listed as the proxy above at any time, except to the extent that ProHealth Care has already taken action in reliance on my authorization. I understand that I can revoke my authorization and terminate the proxy connection for the individual listed as the proxy above by contacting Health Information Management at 262-696-5843 and requesting the **MyChart Inactivation Form**.
- I understand that I have a right to request a copy of this authorization and that I can obtain a copy of this authorization by contacting ProHealth Care Health Information Department at 262-696-5843.

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- I understand that all activities within my MyChart account may be tracked by computer audit, and that entries my proxy makes may become part of my electronic medical record system.
- I understand that access to a MyChart account is provided as a convenience and that access to my MyChart account may be revoked at any time for any reason, including unauthorized or inappropriate actions taken made by my proxy.
- I understand that use of my MyChart account is voluntary, and I am not required to use MyChart or to authorize another person (proxy) to access my MyChart account.
- I understand that my ability to obtain treatment, payment or other services will not be affected if I choose not to provide proxy access to my MyChart account. However, I also understand that if I do not provide authorization, access to my MyChart record will not be granted to my proxy.
- I understand that I am authorizing the use and disclosure of electronic protected health information ("ePHI") through My Chart as described below.
  - Names or classes of organizations authorized to release the ePHI through MyChart:
    - ProHealth Waukesha Memorial Hospital
    - ProHealth Waukesha Memorial Hospital - Mukwonago
    - ProHealth Oconomowoc Memorial Hospital
    - ProHealth Medical Group
    - Participants in the ProHealth Solutions accountable care organization
    - All health care providers who use ProHealth Care's electronic medical record system
  - Description of ePHI to be released: health information available in MyChart
  - The ePHI is being disclosed to allow my proxy to take a more active role in my health care.
- I understand that this authorization permits access to the complete contents of MyChart record.
- I understand that this authorization allows disclosure of PHI to my proxy for to give my proxy information about my healthcare, including, where applicable, information related to substance use disorder.
- I understand that my proxy will have access to records that may include information relating to the diagnosis and treatment of mental illness, all information related to any of my treatment for any substance use disorder, sexually transmitted diseases, developmental disabilities and results of and genetic and HIV tests.
- I understand that granting proxy access to a third party is completely voluntary.
- I understand this authorization is effective on date of signature below and does not expire until I revoke it.
- By signing below, I acknowledge that I have read and understand the authorization. I agree to its terms and grant proxy access to my PHI via MyChart to the individual named in this form.

Signature of Patient: _____ Date: _____
OR
Signature of Authorized Representative: _____ Date: _____

Authorized Representative (please check appropriate box below) Requires a copy of the legal document granting authority.
□ Legal Guardian (court order) □ Power of Attorney for Healthcare (activation) □ Other _____

**Please mail or fax all forms to:**

Health Information Management Identity – Data Integrity
N17 W24100 Riverwood Drive, Suite 200
Waukesha, WI 53188
FAX: (262) 544-9489
mychartadministrator@phci.org


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