

## **MyChart Inactivation 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: 1-866-327887). ATENCIÓN: Si habla español, enemos a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-262-928-4465 (VRS: 1-866-327-887). 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).

Datient Information (all fields are required)

## Instructions for Completing this Form:

To inactivate access to your health information using MyChart you must complete the following steps:

- 1. Complete the Inactivation Form
- Mail the completed form to the following address: Health Information Management ProHealth Care, Inc. N17 W24100 Riverwood Drive Waukesha, WI 53188

Or Fax to: 262-544-9489

Fatient information (all fields are required)	
Patient Name:	DOB:
Address:	Email Address:
City, State, Zip:	Phone Number:
Proxy Information (all fields are required)	
Proxy Name:	DOB:
Address:	Email Address:
City, State, Zip:	Phone Number:
Relationship to Patient:	
<ul> <li>Deactivate my MyChart account</li> <li>I understand that my MyChart account will be inactivated within 30 days of receipt of this form. I understand that all MyChart proxy access to my account will also be inactivated. I understand that will need to complete the enrollment process if I wish to re-enroll in MyChart.</li> <li>Deactivate ONLY my proxy's access to my MyChart account</li> <li>I understand that the MyChart account of the proxy named above will be inactivated within 30 days of receipt of this form. I understand that I will need to complete a new proxy designation if I wish to reactivate my proxy access to my MyChart account.</li> </ul>	
By signing below, I acknowledge that I have read and understand this MyChart Inactivation Form and I agree to its terms.	
Signature of Patient/Legal Representative:	Date:
Relationship to Patient: Da	nte:



