



Edward-Elmhurst MyChart

ADULT PROXY FORM

mychart.eehealth.org

Access to Another Adult's MyChart Record

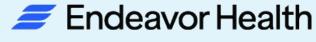
Your Information (All sections required – please print clearly)

To request access to the MyChart record of an adult whose medical care you help manage, please complete this form. The patient must sign this form and provide authorization for release of medical information in MyChart on the 'Adult Proxy Authorization Form'. Please note that the patient's chart will be accessed through your (the proxy's) MyChart record. Completing this form will establish a MyChart record for you and for the patient.

Please return forms to your clinic or physicians office. You can also send them to Edward HIM/Medical Records Department, 801 S. Washington Street, Naperville, IL 60540 or fax to 331-221-2390 OR Elmhurst Memorial Physician Practice Division, Health Information Management Dept, 1200 S. York Road, Ste 2000, Elmhurst, IL 60126 or fax to 331-221-3946.

lame (last, first, middle initial)		Date of Birth		
ast 4 Digits of Social Security Number tient's full SSN must be on file with Edward to activate a MyChart accou	Email			
tient's full SSN must be on file with Edward to activate a MyChart accou treet Address				
hone Number	Primary Physician			
atient's Information (All sections requi	red – please print clearly.)			
his section should be completed by the individual r	equesting access to another adult's MyChart r	ecord.		
lame (last, first, middle initial)		Date of Birt	h	
ast 4 Digits of Social Security Numbertient's full SSN must be on file with Edward to activate a MyChart accou	Email			
treet Address	•			
hone Number	Primary Physician			
I understand that MyChart is intended as a secure online sou person may be able to view my or my child's health informat I agree that it is my responsibility to select a confidential pass compromised in any way. I understand that MyChart contains selected, limited medical medical record. I also understand that a paper copy of a patient I understand that my activities within MyChart may be track I understand that access to MyChart is provided by Edward-deactivate access to MyChart at any time for any reason. I un proxy. I understand that even though I may only be a patient of Edinformation will be shared with the other provider as both p. By signing below, I acknowledge that I have read and unders	sword, to maintain my password in a secure manner, and all information from a patient's medical record and that Ment's medical record may be requested from the patient's ked by computer audit and that entries I make may become Elmhurst Health as a convenience to its patients and that aderstand that use of MyChart is voluntary and I am not ward Hospital & Health Services, Elmhurst Memorial or roviders jointly share MyChart.	horized me as a MyC to change my passwo MyChart does not reflectinic. me part of the patient t Edward Hospital & required to use MyC DuPage Medical Gro s.	hart proxy. ord if I believe it may have been the complete contents of a medical record. Health Services has the right hart or to authorize a MyCloup, my health	
Your (Proxy) Signature	Relationship to Patient		Date (Required)	
acknowledge that I have read and understand this Nove as my MyChart Proxy, thereby allowing them a		nd choose to desi	gnate the person name	
			/	
Signature of Patient (or authorized person)	Relationship to Patient		Date (Required)	





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ADULT PROXY FORM

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Adult Proxy Authorization for Release of Medical Information

This form is an authorization that will permit Edward - Elmhurst Health to release your medical information to your designated adult proxy. Please read it carefully.

This form should be completed by the patient who is authorizing another adult to access medical information in his or her MyChart record. It must accompany the Adult Proxy Form, which provides the name and information of the individual who the patient is authorizing to access their MyChart record as a proxy. If you do not have an Adult Proxy Form, please contact your clinic, or download one from mychart.eehealth.org.

Patient Name (last, first, middle initial)		
Last 4 Digits of Social Security Number_ Patient's full SSN must be on file with Edward-Elmhurst Healthcare to activate a MyChart account	Date of Birth	
I am requesting that information that is available in my Edward-Elmhurst Health MyChart Rec Edward-Elmhurst Health to release the health information contained in medical information in MyChart is obtained from my electronic medical in Health facilities. I authorize release of any information contained in my Medicinated proxy.	cord. This person is my designated MyChart proxy. I authorize by MyChart record to my MyChart proxy. I understand that the record and may include information from all Edward-Elmhurst	
I authorize release of this information only through my MyChart record. The designated proxy by other methods or in other forms.	This form does not authorize release of my medical record to my	
I understand that once information has been disclosed, it potentially may be covered by federal privacy protections.	be re-disclosed by the proxy and the disclosed information may not	
nderstand that even though I may only be a patient of Edward Hospital & Health Services, Elmhurst Memorial or DuPage Medical oup my health information will be shared with the other provider as both providers jointly share MyChart.		
Participation in MyChart and designating a MyChart proxy is completely MyChart proxy and I am not required to provide this authorization. I also any of my health care treatment, payment or other services on whether I p not provide authorization, Edward - Elmhurst Health is not permitted to	understand that Edward - Elmhurst Health does not condition rovide this authorization. However, I also understand that if I do	
This authorization will expire automatically one year from the date of my sproviding a written request for revocation to my primary clinic. I understate to my MyChart record will be ended. I also understand my revocation will revocation request.	and that if I revoke this authorization, my designated proxy's access	
Date Primary Physician	_	
Signature of Patient (or authorized person)		
Printed Name		
If person other than the patient signs, indicate authority to sign for pa	tient (e.g., guardian) and attach documentation:	

NOTE: Authorization expires one year from the date of signature (above). A new MyChart Proxy Authorization Form must be submitted each year to renew proxy access. You also may deactivate the access of the adult proxy specified above at any time through MyChart or by providing a written request to your primary clinic.