22035-03

»MYchart ADULT PATIENT (18+) ACCESS REQUEST AUTHORIZATION FORM

Patient Information (All sections required – please print clearly.)	
NAME (last, first, middle initial):	**DATE OF BIRTH:**
PHONE NUMBER:	

Requestor Information (All sections required – please print clearly.)		
NAME (last, first, middle initial):		**DATE OF BIRTH:**
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP:**
EMAIL:		
PHONE NUMBER:	**PIN (any 4 digit combination):**	

Please check the Requestor's relationship to the patient:

___ Parent
___ Legal Guardian **
___ Durable Power of Attorney for Healthcare (DPOA) **
___ Other *(please specify relationship)* ____

***This request **MUST** be accompanied by a photo ID and a copy of legal paperwork verifying the authority of the patient's personal representative (i.e. court appointed guardian, durable power of attorney for health care).*

Acknowledgement

AS THE ***PATIENT***, I ACKNOWLEDGE AND AGREE THAT:

- I will comply with the terms and conditions on the Mychart web page and this document. I choose to designate the person named above as a proxy to my MYchart account, thereby allowing him/her access to my MYchart protected health information.
- I understand that if I no longer want the Requestor to have access to my MYchart account, I must contact the office/location to which this form was submitted.

____ ____________________

Patient Signature *(for non-guardianship related requests)* **Date**

AS THE ***REQUESTOR***, I ACKNOWLEDGE AND AGREE THAT:

- I have not been denied periods of physical placement with the Patient and there are no court orders or restraining orders in effect limiting access to this Patient's medical records and/or information.
- I will comply with the terms and conditions on the MYchart web page and this document. I have the proper documentation authorizing me as the legal representative for the Patient, thereby allowing me access to his/her protected information through MYchart.
- When my authority to act on behalf of the patient has been inactivated, revoked, terminated or expired, I must immediately notify this institution in writing or the revocation, termination, or expiration.
- The Patient can revoke my access to his/her MYchart account at any time.
- Even if my legal authority to act on behalf of the patient has not been inactivated, revoked, terminated, or expired, my access to the Patient's MYchart protected health information will expire three years from the signature date of this document. I will then need to complete another form to obtain access for another two years.

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Signature of Patient's Personal Representative/Parent/Requestor **Date**

For the patients of Children's Healthcare of Atlanta and our MYchart participating practices.