MyChart©: Adult Proxy Authorization Form

Completion of **ALL** sections is required –please print clearly

Proxy's Information:

Name (Last, first, middle initial):

Date of Birth:

Street Address:	City:	State:	Zip:
E-mail Address:	Phone Number:		**Initials:**

Patient's Information:

Name (Last, first, middle initial):

Date of Birth:

Street Address:	City:	State:	Zip:
E-mail Address:	Phone Number:		**Initials:**

1. This form designates the person named above as the patient's MyChart Proxy, thereby allowing Mount Sinai Medical Center to disclose health information concerning the patient's healthcare to the named Proxy through MyChart and does not authorize the release of the patient's records or patient's health information to the designated proxy by other methods or in other formats.
2. It is understood that the records subject to this authorization include any and all records which pertain to the patient's diagnosis, treatment or care including, without limitation face sheet(s), history and physical examination(s), admission note(s), discharge summary(ies), radiology and laboratory testing, consultation report(s), progress notes, physicians' orders, medication/prescription records, operative and procedure notes, nursing notes, and similar records. It is further understood that the records subject to this authorization may include (if applicable) information relating to sexually transmitted diseases ("STDs"), acquired immunodeficiency syndrome (HIV/AIDS); behavioral and mental health services (including communications with psychiatrists and psychotherapy notes), records of treatment for alcohol and substance abuse, and results of genetic (DNA) testing.
3. It is understood that the use of MyChart is voluntary and that any refusal to sign this authorization will not affect the patient's eligibility for health care services or treatment in any way. It is also understood that the patient is not required to designate a MyChart proxy and that both the patient and the proxy may refuse to sign this authorization.

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4. Both parties understand that by completing this form a MyChart account will be established for the proxy (if one does not currently exist) and that the patient's MyChart account will be accessed through the proxy's MyChart account.
5. It is understood that any disclosure of health information carries with it the potential for an unauthorized re-disclosure, and that any information which is re-disclosed by the proxy may not be protected by federal or state privacy laws. The patient hereby agrees to release and hold Mount Sinai Medical Center harmless for complying in good faith with this authorization.
6. It is understood that this authorization shall remain in effect until revoked. It is further understood that both parties have the right to revoke this authorization at any time, except to the extent that action has been taken by Mount Sinai Medical Center in reliance on it. Revocation of this authorization by either party will terminate the proxy's access to the patient's MyChart account.
7. Either party may request revocation of this authorization at any time by sending an e-mail to MyChartSupport@msmc.com and including a phone number and contact information. It is understood that any such revocation will not be effective until received by the MyChart Support Staff at Mount Sinai Medical Center.
8. It is understood that the use of the MyChart service is subject to the Terms and Conditions and other restrictions which apply to the use of that service as published on the MyChart web site, as amended from time to time.

_____ /_____/_____

Proxy Signature (Required) **Relationship to Patient** **Date**

I acknowledge that I have read and understand this MyChart Adult Proxy Authorization form. I agree to its terms and choose to designate the person named above as my MyChart Proxy, thereby allowing them access to all features within my MyChart account including but not limited to sending/receiving medical messages, requesting prescription refills, managing appointments and reviewing test results.

_____/_____/_____

Patient Signature (Required) **Relationship to Proxy** **Date**