For Office/Hospital Use Only		**For HIS Use Only**
❑ **Proxy Access Granted** ❑ **Needs Proxy Access**	❑ **Activation Letter Sent**	❑ **Proxy Access Granted**

Signed proxy access forms should be faxed to: 260-728-3853, Attention: MyChart, or mailed to:
Adams Memorial Hospital, Health Information Services, Attention: MyChart, 1100 Mercer Avenue, Decatur, IN 46733

Patient Printed Name: ______________________________________ Patient Date of Birth: _____________________________

Patient Street Address: ____ City: ____________________________________

State:_______ ZIP: _____________Patient Social Security Number (**last four digits only**): _____________________________

I authorize Adams Memorial Hospital, all its healthcare providers, and their business units, including Adams Medical Group, (all referred to as "Adams") to share information from my medical records, or the patient for whom I am the legal representative, with the following person by having access to my records through the MyChart web portal.

Name: ____Date of Birth: ________________________________
Street Address: ____
City: ___________________________________State: __________ ZIP: ____________________________________
Relationship to Patient: ____________________________________Phone: ____________________________________

The purpose is to provide access to those portions of my Adams electronic medical record available through MyChart to persons involved with me and my healthcare.

This authorization and the access to my medical records through MyChart shall remain in effect until I revoke or cancel it. This authorization is voluntary. I know that I may revoke or cancel it at any time, except to the extent that action has already been taken in reliance upon it. To revoke or cancel it, I will send a signed and dated letter to: Adams Memorial Hospital, Health Information Services, Attention: MyChart, 1100 Mercer Avenue, Decatur, IN 46733.If I do not sign this form or if I later revoke or cancel my authorization, it will not affect any treatment, payment, or enrollment or eligibility for benefits which I am eligible to receive from Adams.

I confirm that I have had the opportunity to read and consider the contents of this authorization, and I agree to be bound by them. I release Adams from any legal responsibility or liability for providing MyChart access to the person listed above. I understand that this person might not keep my information confidential and that it might not be protected by federal and state privacy laws any longer.

Patient/Parent/Guardian/Legal Representative Signature: ____
Relationship to Patient: __________________________________ Date:_____________ Time: _______________

If guardian or legal representative signs the form, please provide documentation.

Parent/Guardian Authorization for Minor to Access Own MyChart Account

I, (name)___________________________________, the parent/guardian of (child's name) _______________________, who is between the ages of **14 and 17 years old**, authorize him/her to access his/her own MyChart account. I understand that MyChart account holders may give third parties access to portions of their health record using MyChart's Share Everywhere. I authorize my child's use of Share Everywhere and Adams to grant third party access as initiated by my child.

Parent/Guardian Signature: ______________________________________ Date:_____________ Time: _____________