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

For HIM Use Only:
❑ **Proxy Access Granted**

Signed proxy access forms should be faxed to: 260-373-3781, Attention: MyChart, or mailed to:
Parkview Health, Health Information Management, Attention: MyChart, 2200 Randallia Drive, Fort Wayne, IN 46805

Patient Printed Name:_____ Patient Date of Birth:_____

Patient Street Address: _____

City:_____ State:_____ ZIP:_____

Patient Social Security Number (**last four digits only**): _____

I authorize Alliance Health Centers, Inc., (referred to as "Alliance") 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 and MyChart Bedside.

Name:_____ Date of Birth: _____

Street Address: _____

City:_____ State:_____ ZIP:_____

Relationship to Patient:_____ Phone #: _____

The purpose is to provide access to those portions of my Alliance electronic medical record available through MyChart and MyChart Bedside to persons involved with me and my healthcare. Accordingly, I authorize Alliance to share with the above individual all information from my medical records that can be made available to such person through the MyChart portal and MyChart Bedside application which shall include, but not be limited to, lab and other test results, medications, summary of medical problems and history, and other information concerning my treatment and health.

This authorization and the access to my medical records through MyChart and MyChart Bedside shall remain in effect until I revoke this authorization.

This authorization is voluntary. I know that I may revoke it at any time, except to the extent that action has already been taken in reliance upon it. To revoke it, I will send a signed and dated letter to:
Parkview Health, Health Information Management, Attention: MyChart, 2200 Randallia Drive, Fort Wayne, IN 46805.

If I do not sign this form or if I later revoke my authorization, it will not affect any treatment, payment, or enrollment or eligibility for benefits which I am eligible to receive from Alliance.

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 Alliance from any legal responsibility or liability for providing MyChart and MyChart Bedside access to the person listed above. I understand that this person might not keep my information confidential and that it might not be protect 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 Alliance to grant third party access as initiated by my child.

Parent/Guardian Signature:_____ Date:_____ Time: _____

All entries must be dated and timed.

MYCHART PROXY OR MINOR ACCESS AUTHORIZATION

Patient Name: _____

Patient ID Number: _____

DOB: _____