Community Hospitals and Wellness Centers
Bryan · Montpelier · Archbold

MYCHART PROXY OR MINOR ACCESS AUTHORIZATION

(Patient Label)

For Office/Hospital Use Only: ***All entries must be dated & timed.***

☐ Proxy Access Granted ☐ Needs Proxy Access ☐ Activation Letter Sent

For HIM Use Only:

☐ Proxy Access Granted

Patient Name:_____

Patient ID Number:_____

Date Of Birth:_____

Patient Printed Name:_____ Patient Date of Birth:_____

Patient Street Address:_____

City:_____ State:_____ ZIP:_____

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

I authorize CHWC, all its affiliated hospitals and healthcare providers, and their business units 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 CHWC electronic medical record available through MyChart and MyChart Bedside to persons involved with me and my healthcare. Accordingly, I authorize CHWC 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: CHWC, Attn: MyChart, 433 W. High St. Bryan, OH 43506.

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 CHWC. 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 CHWC 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 CHWC to grant third party access as initiated by my child.

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

Signed proxy access forms should be mailed to: CHWC, Attn: MyChart, 433 W. High St. Bryan, OH 43506