OHIOHEALTH MYCHART AUTHORIZATION FOR PROXY ACCESS

About MyChart

MyChart is an optional service that allows you online access to your personal medical information and the ability to communicate online with your health care providers.

"OhioHealth MyChart" is offered to patients of OhioHealth. When the term "MyChart" is used in this document, it referes to both OhioHealth MyChart and MyChart powered by OhioHealth, unless otherwise indicated.

Requirements and Procedures

This form may be used to authorize proxy access to another person's OhioHealth MyChart account. The general requirements for proxy access to an OhioHealth MyChart account record are:

+ This Authorization for Proxy Access form must be completed, with the appropriate information below provided, and signed.
+ Each individual requesting proxy access to a patient's OhioHealth MyChart account record must have their own OhioHealth MyChart account. If the individual requesting access does not have an account, OhioHealth will provide an OhioHealth MyChart Activation Letter with instructions on how to create one.

If the Patient is a Competent Adult:

+ Authorization/Signature. Authorization by the patient is required. The patient must sign this Authorization form.
+ Proxy Designation The patient may designate any other adult of their choosing to have proxy access.
+ Disclosure of Information. The patient understands that this will allow the person designated as proxy to have access to the patient's MyChart account including the medical and billing information contained in MyChart. The patient authorizes the disclosure of this information to the proxy as described in the Authorization section below.
+ Revocation/Termination. The patient may revoke proxy access at any time. Access may also be terminated as provided in the Terms & Conditions.

If the Patient is an Incompetent Adult:

+ Authorization/Signature. Authorization by the patient's representative is required. The representative must be the patient's Legal Guardian or designated in the patient's Durable Power of Attorney for Healthcare, and must sign this Authorization form.
+ Proxy Designation. The patient's representative may designate himself/herself to have proxy access. The patient's representative may also designate any other adult to have proxy access.
+ Disclosure of Information. The patient's representative understands that this will allow the person designated as proxy to have access to the patient's MyChart account including the medical and billing information contained in MyChart. The patient's representative authorizes the disclosure of this information to the proxy as described in the Authorization section below.
+ Revocation/Termination. Proxy access of or granted by a representative is terminated if the individual ceases being the patient's representative (e.g., power of attorney is terminated). Access may also be terminated as provided in the Terms & Conditions.

If the Patient is a Minor:

+ Authorization/Signature. Authorization by the minor's parent or legal guardian is required. The minor's parent or legal guardian must sign this Authorization form. **For minors 14 years old and older, the minor must also provide authorization and sign this form.**
+ Proxy Designation. The parent/legal guardian may designate himself/herself to have proxy access. The parent/legal guardian may also designate any other adult to have proxy access. Individual requesting access as legal guardian must provide appropriate legal documentation of guardianship to OhioHealth.
+ Disclosure of Information. The parent/legal guardian understands that this will allow the person designated as proxy to have access to the minor's MyChart account including the medical and billing information contained in MyChart. The parent/legal guardian authorizes the disclosure of this information to the proxy as described in the Authorization section below.
+ Revocation/Termination. Parent/legal guardian proxy access to a minor patient's OhioHealth MyChart account is revoked when:
  - Parent/legal guardian submits a request to revoke proxy access.
  - A minor patient over 14 years of age submits a request to revoke proxy access.
  - Automatically when the minor patient turns 18 years old (continued access may be requested by submitting appropriate form for family/caregiver access).
  - Minor patient advises OhioHealth of his/her status as an emancipated minor.
  - Access disputes between parent/legal guardian and minor, or between parents, cannot be resolved.

If proxy access of a parent/legal guardian is revoked, the minor patient's OhioHealth MyChart account will be suspended/terminated (a minor may not have an independent account; parent/legal guardian is required). Access may also be terminated as provided in the Terms & Conditions.

+ Special Rules for Minors. Under state and federal law, there are certain types of medical information that a parent/legal guardian of a minor patient may not view without consent of the minor patient. Because of these requirements, proxy access of a minor over 14 years of age is restricted and OhioHealth will use reasonable efforts to exclude such confidential information from proxy access. This restriction will occur automatically upon the minor turning 14. Additionally, a minor over 14 years of age must authorize proxy access and disclosure of such confidential information contained in MyChart to the parent/legal guardian.

Authorization

The patient or patient's representative/guardian/parent authorizes the disclosure of all medical and billing information about the patient contained in the patient's OhioHealth MyChart account to the person granted proxy access as designated below. The purpose of the authorized disclosure is to allow the person granted proxy access as designated below to be able to have on-going access to the medical and billing information in this patient portal to allow the proxy to participate in the medical care of the patient.

OhioHealth

PATIENT IDENTIFICATION LABEL

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The patient or patient's representative/guardian/parent understands that the person receiving proxy access is a not a health care provider or health plan covered by federal privacy regulations and the information accessed by the proxy could be redisclosed by such person and will likely no longer be protected by the federal privacy regulations.

As described above patient or patient's representative/guardian/parent understands that he/she may revoke this authorization in writing at any time, except to the extent that action has been taken by OhioHealth in reliance on this authorization, by sending a written revocation to OhioHealth Health Information Management department or the OhioHealth location where you receive your medical care. This authorization will expire upon revocation by the patient or patient's representative/guardian/parent, upon termination of the patient's MyChart account by OhioHealth, or as otherwise provided above.

The patient or patient's representative/guardian/parent understands that he/she is not required to sign this authorization form and that OhioHealth will not condition the provision of treatment or payment on the signing of this authorization.

Additional Instructions and Agreement

Communications on behalf of the patient must be sent from, and responses will be received in, the patient's OhioHealth MyChart account record. OhioHealth MyChart email alerts will be sent to the email address entered in the patient's OhioHealth MyChart account record.

When using proxy access to view another person's OhioHealth MyChart record, the proxy will log into his/her account and have access from his/her account to the other person's OhioHealth MyChart record. A visual indicator will appear to highlight that the proxy is accessing the OhioHealth MyChart record of that person. If the proxy has access to multiple OhioHealth MyChart records through proxy access, the proxy should verify that he/she is viewing the correct record.

TO BE COMPLETED BY PROXY (INDIVIDUAL REQUESTING ACCESS):

Name: _____ **Social Security #:** _____

Address _____

Email: _____ **Date of Birth:** _____

I have read and understand the requirements and procedures regarding proxy access above. All information I have provided is correct. I understand that:

+ I must have an OhioHealth MyChart account to obtain proxy access to another account.
+ I must log in to OhioHealth MyChart with my own User ID & Password when utilizing proxy access, and will obtain proxy access by selecting "View Other Records" from my account.
+ I agree to abide by the OhioHealth MyChart Terms and Conditions.
+ OhioHealth reserves the right to revoke proxy access to an OhioHealth MyChart account at any time.
+ **OhioHealth MyChart is not to be used to communicate or obtain treatment in an emergency.**

I am requesting proxy access for the patient identified below and I certify that (check one box, as applicable):

_____ I am the Patient's Health Care Power of Attorney

_____ I am the Patient's (circle one): Father / Mother / Legal Guardian

_____ I am the Patient's family/caregiver (describe any family relationship:_____).

Signature of Proxy: _____ **Date:** _____ **Time:** _____

TO BE COMPLETED BY/FOR THE PATIENT:

Name: _____ **Date of Birth:** _____

Address _____

Social Security #: _____ **Male:** _____ **Female:** _____

The undersigned grants proxy access to his/her OhioHealth MyChart record to the person requesting proxy access listed above. Or, for a minor patient or incompetent patient, the undersigned grants proxy access to the patient's OhioHealth MyChart record on behalf of the patient to the person requesting proxy access listed above. **This form must be signed by the patient if a competent adult or a minor over 14 years of age.**

Signature of Patient (or Representative/Guardian/Parent): _____ Date: _____ Time: _____

Signature of Minor (required if over 14 years of age): _____ Date: _____ Time: _____

The minor acknowledges they have read this form and the Terms & Conditions and understands that the minor's parent/guardian will potentially have access to medical information that would otherwise be restricted from disclosure to the parent/guardian.

****To complete this form, please deliver (in person or by mail or fax) to your OhioHealth physician's office.***

For office use only. Name of OhioHealth staff member completing: _____

Confirm that proxy access was approved by patient/patient representative: Yes _____ No _____ Date: _____ Time: _____

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