CHS MyChart Adult Proxy Authorization

BY COMPLETING THIS FORM, YOU ARE GIVING THE NAMED PROXY ACCESS TO YOUR CHS MYCHART RECORDS, WHICH MAY CONTAIN PRIVATE HEALTH INFORMATION.

Patient's Full Name:	
Address:	
Medical Record Number:	**Date of Birth:** / /

I authorize my Provider and Catholic Health Services of Long Island (CHS) to disclose my protected health information through CHS MyChart to my designated proxy named below.

My proxy will only have access to my medical records through the CHS MyChart Site and will not have access through any other source or method. I understand that CHS MyChart contains selected, limited medical information from a patient's medical record and that CHS MyChart does not reflect the complete contents of the medical record. I also understand that a paper copy of a patient's medical record may be requested from the Provider.

I understand that once my health information is disclosed, the proxy may re-disclose the health information about me seen in CHS MyChart. This re-disclosure may not be covered by federal privacy protections. I further understand that CHS MyChart is intended to be a secure online source of confidential health information. If I share my CHS MyChart ID and/or password with another person, that person may be able to view my health information and the health information of anyone who has authorized me as a CHS MyChart proxy.

I understand that my participation in and designation of a proxy to view my CHS MyChart record is voluntary. My participation in or designation of a proxy to use CHS MyChart is not a condition of my health care treatment, payment or other services.

I understand that I can revoke this proxy authorization at any time directly through CHS MyChart or by sending a CHS MyChart message or written request to my health care provider. Once revoked, I understand that the named proxy will no longer have access to my CHS MyChart account. I understand that any information disclosed to the proxy before my written request was received to revoke his/her access will not be affected by the request.

I acknowledge that I have read and understood this authorization. I agree to its terms and choose to designate the person indicated below as my CHS MyChart proxy.

X _____

Signature of Patient **Date**

Proxy Information. (A Proxy is a person who can access your health information as if she/he were you.)

Proxy's Full Name:	
Address:	
Relationship:	**Date of Birth:** / /
