

Palos MyChart Patient Portal

Adult Proxy Authorization

This form is an authorization that will permit Palos to release your medical information to your designated adult proxy through the MyChart Patient Portal. This form should be completed by the

patient who is authorizing another adult to serve as the patient’s proxy to access medical information

in the Palos MyChart Patient Portal.

 **Patient Information** (All sections required-please print clearly.)

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address on file: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Record # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Proxy Information** (All sections required-please print clearly.)

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Record # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Legal Guardian □ Power of Attorney

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ am requesting that the person identified as the proxy above receive access to my health information that is available in the Palos MyChart Patient Portal. I understand and acknowledge that this may include sensitive and confidential information, including information related to mental health, drug abuse and/or alcohol abuse treatment.

I authorize the following access be granted (please check one):

□ Full access (proxy can see and do everything you can see and do in your own MyChart account)

□ Limited access (proxy can schedule appointments, view list of past and future appointments, send and view messages to/from providers)

□ View Record (proxy can view the medical record available on MyChart but cannot schedule appointments or send messages)

I authorize release of this information only through the Palos MyChart Patient Portal. This form does not authorize release of my medical record to my designated proxy by other methods or in other forms (e.g. paper).

I understand that I am not required to designate a proxy. I understand that if I revoke this authorization, my designated proxy’s access to the Patient Portal will be ended.

By signing below, I acknowledge that I have read and understand this Adult Proxy authorization.

**Signature of Patient/Legal Representative\* Relationship to Patient Date (Required)**

\*If signed by legal representative, indicate relationship to patient and attach documentation.

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