## MYCHART PROXY ACCESS

A proxy authorization means you grant another person (your proxy) full access to your records as if they were you. This might be a parent, spouse, adult child, or someone who helps you manage your health. To process your request, all sections must be completed. Please print clearly.

*For office use only.*
*Medical record # _____*

**PATIENT INFORMATION**

Patient Name _____ _____ _____
*last* *first* *middle initial*

Date of Birth _____ Age _____ Last four digits SSN _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

**I designate the following individual as my proxy:** *(Each proxy request requires a separate, completed authorization.)*

Proxy Name _____ _____ _____
*last* *first* *middle initial*

Date of Birth _____ Age _____ Last four digits SSN _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____ Relationship to Patient _____

I allow Riverwood Healthcare Center to release my personal health information to the proxy listed above via an online MyChart account. MyChart is an online service hosted by OCHIN, a third-party vendor, that is independent from Riverwood Healthcare Center. I understand:

- For minors 0-11 years, full proxy access will be granted until the minor's 12th birthday.
- For minors 12-17 years, partial proxy access will be granted until the minor's 18th birthday.
- My proxy will be able to fully access my personal health information maintained in MyChart. To renew access, a new authorization will need to be completed.
- If I change my mind and no longer want my proxy to have access to my MyChart account, I may let Riverwood Healthcare Center know in writing at any time of my intent to revoke this proxy form. Any such revocation will not apply to information that has already been released before the revocation is effective.
- I understand Riverwood Healthcare Center is not responsible for the confidentiality of information released to my proxy and cannot prevent my proxy from releasing the information to another person. At that time, the information is no longer protected by federal and state privacy regulations.
- If I do not sign this form, I will still be treated and payment, enrollment and eligibility for benefits will not be impacted.
- To be valid, this form must be filled out, signed and dated. A photocopy, fax or electronically scanned and transmitted image is the same as the original.

Patient Signature _____

Date _____

Proxy Signature _____

Date _____

Employee Signature_____

Date_____

**UPON COMPLETION MAIL TO:**
Riverwood Healthcare Center
ATTN: HIM Department
200 Bunker Hill Drive
Aitkin, MN 56431

*Patient label*