



1500000

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

ADULT PROXY ACCESS TO MYCHART BY ANOTHER ADULT PROXY AUTHORIZATION FORM

Instructions for completing this form: To request proxy access, please complete this form and fax, mail, or email (either as a scanned attachment or a photo of the form) it to the UVA Contact Center. After the form is received and the information has been verified, you will receive a time sensitive e-mail with access information.

UVA Contact Center

PO Box 800783

Charlottesville, Va. 22908-0793

Email: mychart@virginia.edu Fax: 434-924-7456 Phone: 434-243-2500

For Patient: I have read and understand the information about proxy for MyChart and terms and conditions for using MyChart. I understand that I must have my own MyChart account. I authorize the below named person to access my MyChart account as my Adult Proxy. I understand that this authorization also allows my health care providers to communicate with my Adult Proxy about my health care as well as obtain a copy of my complete medical record if he/she requests. I understand that the information disclosed may be subject to re-disclosure by my Proxy, and would then no longer be protected by federal privacy laws. I understand that the University of Virginia Health System may not condition its providing of health care on whether I sign this authorization.

Patient's Name: _____ Date of Birth: _____

Medical Record Number: _____

Address: _____

Email Address: _____ None

Patient's Signature: _____ Date: _____ Time: _____

Granting proxy access to:

Proxy Recipient Name: _____ Phone: _____

Address: _____

Date of Birth: _____ Email: _____

Medical Record Number: _____ No UVA Medical Record Number

Relationship to patient: Spouse Son/Daughter Other- Please specify: _____

Proxy Recipient Signature: _____ Date: _____ Time: _____

UVA Use Only

Proxy Identification Validated By HIS SW Clinical Support Access

Other: _____

Proxy Access Status: Approved Not Approved Comment _____

Team Member Name: _____ Date: _____ Time: _____

UVA Contact Center Details Activation:

Team Member Name: _____ Date: _____ Time: _____

Deactivation:

Proxy Deactivated Per Request Of: Patient Proxy Other: _____

Team Member Name: _____ Date: _____ Time: _____