UVA Health

1500000

PLACE LABEL HERE.

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

PARENT/LEGAL GUARDIAN/ANOTHER ADULT PROXY ACCESS TO ADOLESCENT MYCHART (CHILD AGED 13-17 YEARS OLD)

Instructions for completing this form:
To request access, please complete this form and either submit it at your clinic visit or to Health Information Services (HIS), or fax, mail, or email (either as an attachment or a photo of the form) to the UVa Contact Center. After the form is received and the information has been verified, you will receive an e-mail with access information.

UVa Contact Center
PO Box 800783
Charlottesville, VA 22908-0783
Email: MYCHART@virginia.edu Fax: 434-924-7456 Phone: 434-243-2500

Adolescent's Information

Full Name (last, first, middle): _____ Date of Birth: _____

Email: _____ Medical Record Number: _____

Parent/Guardian/Another Adult Information

Full Name (last, first, middle): _____ Phone Number: _____

Address: _____

Email: _____ Date of Birth: _____

☐ Full Access to All Information, Including All Records ☐ Bill Pay & Messaging Only

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 above named person to access my entire MYCHART account as my Adult Proxy. I understand that this authorization also allows my health care providers to communicate via MYCHART with my Adult Proxy about my health care as well as obtain a copy of my complete medical record via MYCHART 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.

Adolescent 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:
Deactivation details: _____
Team Member Name: _____ Date: _____ Time: _____