UVA Health

1500000

PLACE LABEL HERE.

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

PROXY ACCESS TO MY-CHART FOR"CAREGIVERS"

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

Incapacitated Patient Information

Patient's Name: _____ Medical Record Number_____

Date of Birth: _____ Address _____

Adult Seeking Proxy Access as Caregiver to Incapacitated Patient Information

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 certify that I am a caregiver of the above named patient. All information I have provided is correct. If the patient regains capacity he/she may deactivate the proxy access. I hereby request access to this patient's My-Chart account.

Proxy Recipient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Email: _____

Medical Record Number: _____ ☐ No UVa Medical Record Number

Relationship to patient**:** ☐Spouse ☐Son/Daughter ☐Parent/Legal Guardian ☐Other: _____

Legal Surrogate by**:** ☐ Advance Directive ☐ Power of Attorney ☐ Guardianship

☐ Virginia hierarchy for legal agent ☐Other: _____

Proxy Recipient Signature _____ Date_____ Time_____

Capacity Review: Please have either the UVa Licensed Independent Provider complete the following section **or** include legal documentation that proves patient capacity and your legal status as caregiver.

UVa Licensed Independent Provider Review of Proxy for Incapacitated Patient

☐ I have verified the capacity of the patient and the relationship of the person seeking proxy access for the patient's MyChart account **OR**

☐ UVa Form 070861-Certification of Adult Patient Capacity to Consent to Treatment has been completed

Name_____ Signature_____

Date_____Time_____

Legal Documentation Enclosed (Check all that apply):

☐ Advanced Directive ☐ Power of Attorney ☐ Guardianship

☐ Other/Comments_____

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_____