



PLACE LABEL HERE.

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

ADULT 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 Adult Patient Information

Patient's Name: _____ Medical Record Number _____

Date of Birth: _____ Address _____

Adult Seeking Proxy Access as Caregiver to Incapacitated Adult 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. This proxy access must be renewed including capacity review every 180 days. 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 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 Adult

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 _____