UVA Health

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 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.

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: _____