



Request to Access Another Patient's MyHealth Record

Patient Information

Patient Last Name	Patient First Name	Middle Name
Nickname/Maiden/Other Name		Birth Date
Patient Address		Telephone#

Request Type	Additional Required Documentation
1. <input type="checkbox"/> Your minor child (age 13 or younger)	
2. <input type="checkbox"/> Your minor child (age 14 to 18)	<i>Authorization to Use and Disclose Protected Health Information</i> form signed by your child (the patient)
3. <input type="checkbox"/> An adult	<i>Authorization to Use and Disclose Protected Health Information</i> form signed by patient
4. <input type="checkbox"/> A parent or an adult you care for (an individual for whom you are a legal caregiver or personal representative)	A copy of legal documentation showing your authority as the personal representative (i.e. legal guardian, health care representative, or durable power of attorney for healthcare). <u>You agree to inform the patient's clinic immediately if your legal relationship with the individual changes.</u>

Person Requesting Access

Last Name	First Name	Date of Birth:
Address:		Telephone#
Email Address:		
Signature	Social Security Number	Relationship to Patient
Date		
Primary Care Provider		Location of Primary Care Provider

For Legacy Use Only

- Reviewed and verified form _____ initials
 - Reviewed and verified Authorization Form for request types 2 and 3 _____ initials
 - Legal Representative's Documentation received and verified for request type 4 _____ initials
 - Proxy activated in Epic _____ initials
- Scan forms into Epic.

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Authorization for Proxy Access
Authorization to Use and Disclose Protected Health Information

I, _____ allow Davies Clinic, PC to grant
(Patient Name and Date of Birth)

Mychart Proxy Access to _____ / _____
(Name of authorized person) (relationship to patient)

Effective this date, _____. **It is in my responsibility to notify Davies**
(today's date)

Clinic, in writing, if there is a change in relationship or to cancel access.

(Signature of Patient)

(Date)