MyChart Adult Proxy Request Form

BalladHealth

Patient Identification

This form should be completed by a patient of BALLAD HEALTH, its affiliated clinics and entities (the "Organizations") who is 18 or over and **can make (and understand) his/her health care decisions** and wants to grant another person ("Proxy") access to portions of the patient's electronic protected health information ("ePHI") maintained at the Organizations through MyChart. The patient will need to show a photo ID.

Patient Information: Verify pre-printed information, complete all gray items, and then sign below under Patient. **If the patient will be logging into his/her MyChart account, the patient also needs to complete the Enrollment Form if not already completed.**

Patient's Name:	DOB:
Address:	Medical Record #:
Phone Number:	Last 4 SSN:

Proxy Information: If the Proxy sees providers at the Organizations, the Proxy needs to also complete the Enrollment Form if not already completed.

Email Address:	DOB:	
Proxy's Name:	Phone #:	
Street Address:	Last 4 SSN:	
City:	State:	Zip:

Proxy:

By signing below, I acknowledge and agree that:

- I will be using my own MyChart account at the Organization to access the Patient's account.
- I will comply with the MyChart terms and conditions and the conditions set forth in this document.
- The patient can revoke my access to his/her MyChart account at any time.

X_____/ _____/ _____

Proxy Signature (Required) Relationship to Patient Date (Required)

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Patient:

By signing below, I acknowledge and agree that:

- I will comply with the terms and conditions on the MyChart web page (located at _____), then select the Terms and Conditions link on the page) and this document.
- I choose to designate the person named above as a Proxy to my MyChart account, thereby allowing him/her access to the ePHI in my MyChart account.
- I understand that if I no longer want the Proxy to have access to my MyChart account, I may either revoke his/her access by going into my MyChart account under My Account- My Family's Records, click the button next to their name and click Revoke Access or do so in writing and mail it to:
  400 North State of Franklin Road, Johnson City TN 37601
- I have completed the MyChart Authorization for Use or Disclosure of Electronic Protected Health Information.

_____ _____ _____

Date Time Patient Signature

For Official Use:

1. I have given a photocopy of the signed MyChart Authorization documents to the Patient.
2. I HAVE PLACED A PATIENT LABEL ON EACH OF THE PAGES GOING TO MEDICAL RECORDS.
3. I have viewed the Patient's photo ID on _____ by: _____

Date: _____ *Signature of:* _____