New Hanover Regional Medical Center

Name: _____ _____ _____
(Last Name) (First Name) (Middle Initial)

DOB: _____ MRN#: _____

HAR#/DAR#: _____ CSN#: _____

NHRMC AND AFFILIATED COVERED ENTITIES
MyChart ADULT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

This authorization will permit NHRMC and its affiliated covered entities to release your medical information to your designated adult proxy. Please read it carefully.

This form should be completed by the patient who is authorizing another adult to access medical information in his or her MyChart record. It must accompany the Adult Proxy Request, which provides the name and information of the individual who the patient is authorizing to access their MyChart record as a proxy.

Patient name (last, first, middle initial): _____

Social Security #: (last five digits only): XXX-X_____ Date of Birth: _____

I am requesting that _____ (insert name of proxy) receive access to my NHRMC and its affiliated covered entities MyChart record. This person is my designated MyChart proxy. I authorize the release of the health information contained in my MyChart record to my MyChart proxy. I understand that the medical information on MyChart is obtained from my electronic medical record and may include information from NHRMC and the affiliated covered entities. I authorize release of any information contained in my MyChart record held by NHRMC to my designated proxy. This may include sensitive information pertinent to substance abuse, birth control, sexually transmitted infections and mental health.

I authorize release of this information only through my MyChart record. This form does not authorize release of my medical record to my designated proxy by other methods or in other forms.

I understand that once health information has been disclosed, the recipient may potentially re-disclose that information and the disclosed information may no longer be covered by federal privacy protections.

Participation in MyChart and designating a MyChart proxy is completely voluntary. I understand that I am not required to designate a MyChart proxy and I am not required to provide this authorization. I also understand that NHRMC and its affiliated covered entities does not condition any of my health care treatment, payment or other services on whether I provide this authorization. However, I also understand that if I do not provide authorization, NHRMC and its affiliated covered entities are not permitted to provide access to my MyChart record to my designated proxy.

This authorization will expire one year from the date of my signature. I may also revoke this authorization at any time by providing a written request for revocation to NHRMC Attn: Health Information Management POB 2400 Wilmington, NC 28402. I understand that if I revoke this authorization, my designated proxy's access to my MyChart record will be ended. I also understand that my revocation will not affect any disclosures that were made prior to processing the revocation request. I also understand that I must submit a new proxy request each year in order to renew proxy access.

Signature: _____ Date: _____
(Patient or Authorized Representative)

Printed name: _____

If person other than the patient signs, indicate authority to sign for patient (e.g., guardian) and attach documentation.

THIS FORM IS PART OF THE PERMANENT MEDICAL RECORD

New Hanover Regional Medical Center

Name: _____ (Last Name) _____ (First Name) _____ (Middle Initial)

DOB: _____ MRN#: _____

HAR#/DAR#: _____ CSN#: _____

NHRMC AND AFFILIATED COVERED ENTITIES
MyChart ADULT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Access to Another Adult's MyChart Record

To request access to the MyChart record of an adult whose medical care you help manage, please complete this request. The patient must sign this form and provide authorization for release of medical information on the MyChart Adult Proxy Authorization for Release of Medical Information (NS-2140). Please note that the patient's chart will be accessed through your (the proxy's) MyChart record. Completing this request will establish a MyChart record for you and/or for the patient.

Return all forms to: NHRMC Attn: HIM Department PO Box 2400 Wilmington, NC 28402
or Fax (910) 667-5631

Requestor's Information - This should be completed by the individual requesting access to another adult's MyChart record. (Complete all sections – please print clearly)

COPY OF PHOTO ID REQUIRED: (Drivers License, State issued ID, Military ID, Passport)

Name (last, first, middle initial): _____

Social Security #: (last five digits only): XXX-X_____ **Date of Birth:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Email:** _____

Patient's Information – Complete this section with information about the patient whose MyChart record you are requesting to access. (Complete all sections – please print clearly)

COPY OF PHOTO ID REQUIRED: (Drivers License, State issued ID, Military ID, Passport)

Name (last, first, middle initial): _____

Social Security #: (last five digits only): XXX-X_____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

- I understand that MyChart is intended as a secure online source of confidential information. If I share my MyChart ID and password with another person that person may be able to view my or my child's health information, and health information about someone who has authorized me to act as a MyChart proxy.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.
- I understand that MyChart contains selected, limited medical information from a patient's medical record and that MyChart does not reflect the complete contents of the medical record. I also understand that a copy of a patient's medical record may be requested from NHRMC Health Information Management Department.
- I understand that my activities within MyChart may be tracked by computer audit and that entries I make may become part of the medical record.
- I understand that access to MyChart is provided by NHRMC as a convenience to its patients and that NHRMC and affiliated covered entities have the right to deactivate access to MyChart and that the patient may terminate my access to that patient's health information at any time for any reason. I understand that use of MyChart is voluntary and I am not required to use MyChart or to authorize a MyChart proxy.
- By signing below, I acknowledge that I have read and understand this MyChart Proxy Request and I agree to its terms. I also understand that use of MyChart may be subject to other Terms and Conditions, which may change from time to time.

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

I acknowledge that I have read and understand the MyChart Adult Proxy Request. I agree to its terms and choose to designate the person named above as my MyChart Proxy, thereby allowing that person to access my MyChart medical record.

_____ _____ _____
Signature of Patient or authorized representative (Required) Relationship to Patient Date

THIS FORM IS PART OF THE PERMANENT MEDICAL RECORD

1595
MyChart Proxy