EP-00007

JOHNS HOPKINS MEDICINE **Scan into patient record once completed**
Proxy Access Form – By Authorization

JOHNS HOPKINS MEDICINE MYCHART
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
(please print clearly)

Patient Name: _____ **Birth Date:** _____
(first) (m. initial) (last)

Address: _____ **Phone #:** _____
(street address)

_____ **Medical Record #:** _____
(city) (state) (zip code) (if known)

I authorize Johns Hopkins Medicine to grant the person named ("My Proxy") access as specified below to my Johns Hopkins Medicine medical record available in MyChart**.** If My Proxy is a Johns Hopkins Medicine patient, the person named will need to have an active MyChart account to access my MyChart information. If My Proxy is not a Johns Hopkins Medicine patient, a MyChart account will be created for the person named once this form has been processed.

Proxy's Name: _____ **Birth Date:** _____
(first) (m. initial) (last) (***required***)

Address: _____ **Phone:** _____
(street address) (***required***)

_____ **E-Mail Address:** _____
(city) (state) (zip code - ***required***) (***required***)

Last 4 digits of My Proxy's SSN (for matching purposes if My Proxy has been a patient at Johns Hopkins)**:** _____

Proxy Access to be Granted (check only one):

☐ **Full Access** – access to all MyChart proxy features (for minors – as otherwise permitted)

☐ **Scheduling Only** – access to appointment and scheduling features only

Proxy Access Expiration (check only one):

☐ **Expiration Date: _____/_____/_____**

☐ **Valid for as long as My Proxy is involved in my care**

I understand that:

- This Authorization is voluntary. I am not required to designate a MyChart proxy. My treatment will not be impacted, whether or not I sign this Authorization.
- This Authorization is valid for as long as specified above, unless I revoke/withdraw this Authorization. I may revoke/withdraw this Authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to the clinic or department where my Authorization was made or given.
- Once Johns Hopkins discloses health information as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by My Proxy.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse or other sensitive information.
- By signing below, I acknowledge that I have read and understand this MyChart Authorization and the MyChart terms and conditions, and I agree to their terms.

Signature of Patient Only: _____ **Date**: _____/_____/_____
(***required***)

If you are NOT the patient but are signing on behalf of the patient, please complete below.

I, _____, **am the (check which applies)**
(print your name)

- ☐ **Parent with Parental Rights** *(applies only to minor children under 18)*
- ☐ **Legal Guardian**
- ☐ **Legally Appointed Healthcare Agent and the Patient is incapacitated**
- ☐ **Medical Power of Attorney and the Patient is incapacitated**

Representative's Signature: _____ **Date**: _____/_____/_____
(***required***)

Address: _____ **Phone**: _____

You MUST attach proof of your authority to act on behalf of the patient as checked above (other than parent).