COMMUNITY
MEDICAL CENTERS

Proxy Access to Adult MyChart Account

This form is an authorization that will permit Community Medical Centers (CMC) and affiliated physicians to release my health information to a designated adult Proxy. By completing this form, I am authorizing another adult ("Proxy") access to my MyChart account.

I understand that by authorizing the Proxy to have access to my account, the Proxy will be able to view all health information available now or later through MyChart. This may include the release of content related to drug and alcohol abuse, mental health, HIV/AIDS test results and genetic testing information as specified in MyChart Terms and Conditions.

Patient Information

Patient's Name: _____

DOB: _____ Medical Record Number (if known): _____

Social Security Number: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

I authorize the Proxy below to have access to MyChart account:

Proxy Information

In order to view the Patient's information, the Proxy must also obtain their own MyChart account.

Proxy's Name: _____

Proxy's Relationship to the Patient: _____

DOB: _____ Phone: _____

*Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Email address (required): _____

*A Social Security Number is required in order to process a request for proxy access. It uniquely identifies you.

General Acknowledgements

I understand that:

1. I may revoke this authorization at any time directly in MyChart.
2. If I revoke this authorization, the revocation will not have any effect on any actions taken prior to CMC receiving the revocation.

ORIGINAL - MEDICAL RECORDS
COPY - PATIENT

3. This authorization will automatically expire 10 years from the date signed by Patient, or sooner if revoked by the Patient as stated on previous page.
4. I have a right to receive a copy of this authorization.
5. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality law (Health Insurance Portability and Accountability Act). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

Authorization and Acknowledgement by Patient

Date	Time	Patient/Legal Representative Signature	Print Name

If signed by someone other than the patient, indicate relationship

Proxy Acknowledgement

By signing below, I acknowledge and agree that:

- I will be using my own MyChart account to access the Patient's MyChart account.
- I will comply with the MyChart Terms and Conditions for use of MyChart, available upon activation of a MyChart account.
- I will keep my password confidential and not share this information with anyone.

Date	Time	Proxy Signature	Print Name

Return the completed form to:
Community Medical Centers, Attn: HIM Department (Proxy)
Mail: P.O. Box 1232, Fresno, CA 93715
Fax: (559) 459-2412

For Official Use: ☐ CRMC ☐ CCMC ☐ FHSH ☐ Physician Office – List Office _____

(Proxy access will *not* be activated if 1-2 below are not completed)

1. Patient/Legal Representative ID Verified: ☐ Yes Date: _____
2. Printed name and phone # of person verifying Patient ID:

   _____

3. CMC Representative Only: Date Proxy Access activated _____ Initials _____

Health Information Management
MyChart Adult Proxy Access Form