Proxy Access Form – Adult Patients Only

Patient Information

- Patient Name: _____
- Patient Date of Birth: _____
- Patient Street Address: _____
- City: _____
- State: _____
- Zip: _____
- Patient social security Number (last four digits only): _____

If Applicable, Court-Appointed Proxy Relationship:

☑ Court-Appointed Legal Guardian for this adult proxy

☑ Court-Appointed Legal Healthcare Representative for this adult proxy

☑ Persons holding POA and those designated as a Healthcare Representative

Proxy Information

I authorize Riverview Health, all its affiliated hospitals and healthcare providers, and their business units, including Riverview Physicians Group, (all referred to as "Riverview") to share information from my medical records, or the patient for whom I am the legal guardian or healthcare representative, with the following person by having access to my records through the MyChart web portal and MyChart Bedside. If this form is being completed by a legal guardian or health care representative, all references to "me" and "my" are referring to the patient for whom I am the legal guardian or health care representative".

- Name: _____
- Date of Birth: _____
- Street Address: _____
- City: _____
- State: _____
- Zip: _____
- Phone #: _____
- Relationship to Patient: _____

The purpose is to provide access to those portions of my Riverview Health electronic medical record available through MyChart and MyChart Bedside to the persons involved with me and my healthcare.

Accordingly, I authorize Riverview Health to share with the above individual all information from my medical records that can be made available to such person through the MyChart portal and MyChart Bedside application which shall include, but not be limited to, lab and other test results, medications, summary of medical problems and history, and other information concerning my treatment and health.

This authorization and access to my medical records through MyChart and MyChart Bedside shall remain in effect until I revoke this authorization.

This authorization is voluntary. I know that I may revoke it at any time, except to the extent that action has already been taken in reliance upon it. To revoke it, I will revoke access to my own MyChart account directly or submit a Proxy Support message requesting the removal of a proxy on anyone else I am proxy on. If I do not have a MyChart account, I will send a signed and dated letter to **HIM@riverview.org**, requesting this proxy access be revoked or cancelled.

If I do not sign this form or if I later revoke my authorization, it will not affect any treatment, payment, enrollment, or eligibility for benefits that I am eligible to receive from Riverview Health.

I confirm that I have had the opportunity to read and consider the contents of this authorization, and I agree to be bound by them. I release Riverview Health from any legal responsibility or liability for providing MyChart and MyChart Bedside access to the person listed above. I understand that this person might not keep my information confidential and that it might not be protected by federal and state privacy laws any longer.

- Authorization (Checkbox): _____
- Patient/Parent/Guardian/Legal Representative Signature: _____
- Date of Signature: _____
- Relationship to Patient: _____

Additional Information:
Please provide any additional information necessary to explain the proxy request situation (if needed).
_____
_____
_____
_____

Once completed, this form must be emailed by yourself or your proxy to **HIM@riverview.org** for processing. Send a secure email if possible as email transactions are not encrypted and may be viewed by a third party. Processing of forms can take up to three (3) business days.