



**Access to Another Adult’s MyChart Record**

To request access to your MyChart record be given to another adult, called a “proxy”, please complete this form and return it, in person, to the Yakima Valley Farm Worker’s Clinic (the “Clinic”) where you receive your primary care. Please note that your chart will be accessed through the proxy’s MyChart account. If the proxy does not already have a MyChart account, the Clinic will establish one for the proxy. When you bring this form in to your primary care clinic you will need to provide a government-issued ID for identity verification.

**Remember, you must return this form to your primary care clinic.**

**Proxy Information (All sections required – please print clearly.)**

This section should be completed by the person who the patient wants to have access to his or her MyChart record.

Name (last, first, middle initial): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number (home/mobile/work – please circle one): \_\_\_\_\_ Email Address: \_\_\_\_\_

Are you a YVFWC patient (please circle one): yes/no \_\_\_\_\_

What’s your relationship to the patient: \_\_\_\_\_

**Your Information (All sections required – please print clearly.)**

Complete this section with information about the patient whose MyChart record is to be accessed by the proxy.

Name (last, first, middle initial): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**MyChart Terms and Agreement**

- I understand that by granting proxy access to a third party, I am allowing that party access to the complete contents of my record in MyChart. I authorize release of this information only through MyChart. 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 information has been disclosed, it potentially may be re-disclosed by the proxy and the disclosed information may not 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 Clinic 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, Clinic is not permitted to provide access to my record in MyChart to my designated proxy.
- I understand that it is my responsibility to terminate my proxy’s access to my account in MyChart if I no longer wish to allow him/her access to my information in MyChart. Termination of proxy access is not immediate. I understand that Clinic will use its best efforts to terminate the proxy’s access within ten (10) business days of receiving a written request.
- I understand that I may receive information through MyChart from my provider that may contain specially protected health information such as but not limited to; Drug/Alcohol diagnosis, treatment or referral information, HIV/AIDS information, Mental Health information – including provider notes, and Genetic testing information.
- I understand that if my proxy shares his/her user ID and password with anyone, or if his or her user ID and password are lost or stolen, unauthorized parties may have access to MyChart. I understand that it is the responsibility of my proxy to keep his/her user ID and password secure and to change them anytime they believe their security has been compromised. I agree that it is also the responsibility of my proxy to log out of active MyChart sessions and take appropriate precautions when accessing MyChart from his/her home, business, or public computer and when printing or copying any MyChart medical information.
- I understand that my proxy will receive an email notification any time new information is available in my account in MyChart. The notification itself does not contain any medical information; however I understand that if I do not want others to see the notification, it is my responsibility to notify my proxy so he/she can take appropriate precautions.
- I understand that my proxy’s activities within MyChart may be tracked by computer audit and that any entries and messages may become part of the medical record.
- I understand that access to MyChart is provided as a convenience and that Clinic has the right to deactivate my access or my proxy’s access at any time for any reason or for no reason.
- I hereby agree to waive any and all claims or causes of action against Clinic, its affiliated entities, their officers, directors, employees, and agents that are in any way related to my proxy’s use of MyChart.

I acknowledge that I have read and understand the contents of this form. I agree to its terms and choose to designate the person named above as my Proxy with respect to MyChart Account, thereby allowing my Proxy access to my medical record in MyChart.

\_\_\_\_\_  
**Signature of Patient (or authorized person)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Relationship to Patient**

**By signing below, I acknowledge that I have read and understand the contents of this form, and attest that I am the authorized proxy of the patient.**

\_\_\_\_\_  
**Your (Proxy) Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Relationship to Patient**

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

For Official Yakima Valley Farm Workers Clinic Use:

**Signature Verification**

\_\_\_\_ Verified by ID (Driver's License, State ID, Military ID)    \_\_\_\_ Form signed in person    \_\_\_\_ Signature on File

Completed By: \_\_\_\_\_