Wellstar MyChart

Teen Plus Proxy and Authorization for Release of Medical Information

Email form to: mycharthelp@wellstar.org **OR Fax form to:** 770-999-2306
If you need assistance, please call the MyChart Help Desk at 470-644-0419

Section 1: Teen Plus Proxy Authorization for Release of Information (to be filled out by PATIENT)

This section is an authorization that will permit Wellstar Health System to give your parent or legal guardian access to your MyChart account. Please read it carefully. PLEASE NOTE that you do not have to give your parent or legal guardian access to your MyChart account. If you want to deny Teen Plus MyChart Proxy access to your parent or legal guardian, please fill out Section 3 of this form.

This section should be completed by the patient who is authorizing an adult to access medical information in his or her MyChart record. It must accompany the Teen Plus Proxy Request on page 2 of this form, which provides the name and information of the individual whom the patient is authorizing to access their MyChart record as proxy. This form MUST be completed in your physician's office.

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

Social Security Number: _____ Date of Birth: _____

I am requesting that (insert name of proxy) _____ receive access to my health information that is available in my Wellstar MyChart record. This person is my designated MyChart proxy. I authorize Wellstar Health System to release the health information contained in my MyChart record to my MyChart proxy. I understand that the medical information in MyChart is obtained by my electronic medical record and may include information from all facilities listed in Wellstar's practice directory. I authorize release of any information contained in my MyChart medical record held by Wellstar Health System to my designated proxy.

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 information has been disclosed, it potentially may be re-disclosed by the proxy and the 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 proxy and I am not required to provide this authorization. I also understand that Wellstar 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, Wellstar is not permitted to provide access to my MyChart record to my designated proxy.

This authorization will expire automatically when I reach age 18 or request revocation. I may revoke this authorization at any time by contacting MyChart or my primary clinic. I understand that if I revoke this authorization, my designated proxy's access to my MyChart record will end. I also understand my revocation will not affect any disclosures that were made prior to processing the revocation request.

_____ _____
PATIENT / Authorized Person Signature Date

_____
Relationship to patient (if authorized person)

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

NOTE: Authorization expires when you reach age 18. You also may deactivate the access of the Teen Plus proxy specified above at any time through MyChart or by contacting your primary clinic.

Section 2: Teen Plus Proxy Request (to be filled out by ADULT PROXY)

To request access to the MyChart record of a Teen Plus (ages 12 - 17) patient whose medical care you help manage, please complete this section. The Teen Plus patient must sign this form on page 1 to grant proxy access and provide authorization for release of medical information in the MyChart record. Please note that the Teen Plus patient's chart will be accessed through your (the proxy's) MyChart record. Completing this section will establish a MyChart record for you and for the Teen Plus patient.

Your (Adult Proxy) Information
This section should be completed by the individual requesting access to a Teen Plus patient's MyChart record
All information required - please print clearly

Adult Proxy Name (last, first, middle initial): _____

Social Security Number: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Email address: _____ Phone number: _____

Patient (Teen Plus) Information
Complete this section with information about the patient whose MyChart record you are requesting to access
All information required - please print clearly

Teen Plus Patient Name (last, first, middle initial): _____

Social Security Number: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Email address: _____ Phone number: _____

MyChart Terms and Conditions

- I understand that MyChart is intended as a secure online source of confidential medical 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 information about someone who has authorized me 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 paper copy of a patient's medical record may be requested from Wellstar's Release of Information department at 770-810-8880.
- 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 Wellstar Health System as a convenience to its patients and that Wellstar Health system has the right to deactivate access to MyChart at any time for any reason. I understand that use of MyChart is voluntary and I am not required to use MyChart or authorize a MyChart proxy.
- I acknowledge that I have read and agree to these terms and conditions.

_____ _____
ADULT PROXY Signature Date

_____
Relationship to patient

Section 3: Teen Plus Proxy REFUSAL for Release of Information (to be filled out by PATIENT)

Please fill out this section if you refuse to give your parent or legal guardian access to your MyChart record.

r I DO NOT authorize _____ (parent or legal guardian) to receive access to my MyChart record.
I DO understand that I will be given my own MyChart account.
I DO understand that my denial does not affect any legal rights my parent or legal guardian has to request my medical record by other means.

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- 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 paper copy of a patient's medical record may be requested from Wellstar's Release of Information department at 770-810-8880.
- 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 Wellstar Health System as a convenience to its patients and that Wellstar Health system has the right to deactivate access to MyChart at any time for any reason. I understand that use of MyChart is voluntary and I am not required to use MyChart or authorize a MyChart proxy.
- I acknowledge that I have read and agree to these terms and conditions.

_____ _____
PATIENT / Authorized Person Signature Date

_____
Relationship to patient (if authorized person)

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

NOTE: Authorization expires when you reach age 18. You also may deactivate the access of the Teen Plus proxy specified above at any time through MyChart or by contacting your primary clinic.

Office Use Only

r I have counseled the patient on his or her right to allow or deny their parent or legal guardian access to their MyChart account.

_____ _____ _____ AM / PM
Staff Signature Date Time