OSF MyChart Adult Proxy Form

PATIENT Information (Please print)

Patient Name: _____ _____/_____/_____
Last First Middle Date of Birth

Address: _____
Street City State Zip

Social Security # (last 4 digits): XXX-XX-_____ Phone number: _____

PROXY Information

Proxy Name: _____ _____/_____/_____
Last First Middle Date of Birth

Address: _____
Street City State Zip

Social Security # (last 4 digits): XXX-XX-_____ Phone number: _____

Email address (Required): _____

Choose one (1) applicable OSF MyChart access below

☐ **Capable Adult Patient:** **Includes emancipated minor – must have proof of emancipation*

- Patient who is authorizing another adult to access their medical information through OSF MyChart.
- Authorization expires upon death. Access may be revoked at any time by the patient, proxy, or OSF HealthCare.

☐ **Incapacitated Adult Patient:** **Legal documentation must be present in patient chart*

Select one of the options below:

☐ Power of Attorney for Health Care
☐ Legal Guardian

By signing this form:

- I understand that participation in OSF MyChart and designating a 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 OSF HealthCare does not condition any of my health care treatment, payment, or other services whether I provide this authorization. However, I also understand that if I do not provide authorization, OSF HealthCare is not permitted to provide access to my OSF MyChart account to my designated proxy. I authorize OSF HealthCare to allow access to the health information contained in my OSF MyChart account to my designated proxy.
- I understand that the medical information in OSF MyChart is obtained from my electronic medical record and may contain sensitive information including, but not limited to, HIV/AIDS related health information and/or records, behavioral or mental health information and/or records, information about sexually transmitted disease (STD), pregnancy, birth control, drugs/alcohol diagnosis, treatment, and/or referral information, genetic testing information and/or records, information about sexual assault/abuse, and information about child abuse and neglect, etc. from all facilities listed in the OSF HealthCare System Notice of Privacy Practices.
- I understand that a proxy has the same access to message providers, request prescription refills, schedule appointments, and any other information the patient has access to in OSF MyChart.
- I authorize access to all existing and future information contained in my OSF MyChart account held by OSF HealthCare System by my designated proxy.
- I understand this authorization expires upon death. Access may be revoked at any time by the patient, proxy, or OSF HealthCare.

I acknowledge that I have read and understand this form and I agree to its terms. I further agree to any and all current and future terms and conditions noted at https://www.osfmychart.org.

_____ / _____/_____/_____
Patient Signature (Required if capable adult) Date (Required)

_____ /_____ / _____/_____/_____
POA/Legal Guardian Signature (Required if incapacitated adult) Relationship to patient (Required) Date (Required)

_____ / _____/_____/_____
Mission Partner Signature #1 (Required) Date (Required)

_____ / _____/_____/_____
Mission Partner Signature #2 (Two witnesses required for verbal request) Date (Required)