Medical Record #_____

Patient Information

Full Name _____ Date of Birth _____

Email Address _____ Social Security Number: XXX-XX-_____ (last 4 digits)

Address _____
City State Zip

Day Phone #_____ Cell # _____

Parent/Guardian/Legal Personal Representative

Full Name _____ Date of Birth _____

Email Address _____ Social Security Number: XXX-XX-_____ (last 4 digits)

Relationship to Patient _____ I have my own personal SCL Health MyChart account: ☐ Yes ☐ No

Address _____
City State Zip

Day Phone #_____ Cell # _____

Additional Parent/Guardian/Legal Personal Representative

Full Name _____ Date of Birth _____

Email Address _____ Social Security Number: XXX-XX-_____ (last 4 digits)

Relationship to Patient _____ I have my own personal SCL Health MyChart account: ☐ Yes ☐ No

Address _____
City State Zip

Day Phone #_____ Cell # _____

I Understand That

- Legal documentation (e.g. Medical Power of Attorney, Guardianship, Legal Personal Representative) is required.
- If access to the patient's SCL Health MyChart is granted, access will remain in effect until **revoked t**hrough MyChart or in writing at any time.
- If access to SCL Health MyChart is revoked, the information previously viewed by the above named person(s) would not be considered a breach of confidentiality.
- Information accessed may be subject to **redisclosure** by the Parents/Guardians/Legal Representatives and is no longer protected by the HIPAA Privacy rule.
- The patient's SCL Health MyChart may include a diagnosis or reference to the following condition(s): *behavioral health services/psychiatric care; sickle cell anemia; genetic testing; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); or drug and/or alcohol abuse.*
- SCL Health reserves the right to revoke access to the SCL Health MyChart at any time for any reason.

A signature is required to validate this request. By signing this form, the signer is requesting that the person(s) named above be granted access to electronically view the patient's medical record via the SCL Health MyChart.

_____

Signature and PRINTED Name of Parent/Guardian/Legal Personal Representative Date

Submit Completed Form To

Return Completed Form to: The SCL Health Clinic where the patient last received services or the Hospital's Health Information Management Department.

Direct Questions to: SCL Health MyChart Patient Support Line toll free at 855-274-2517.

For Office Use Only

Date Request Received: _____ By: _____

Date Request Completed: _____ By: _____

Identification/Driver's License Verified: _____ (initials)

Requestor: ☐ Access granted ☐ Access denied

Additional Requestor: ☐ Access granted ☐ Access denied

SCL Health

ON107

Request for MyChart PROXY Access (For Use By Parents/Guardians/Legal Personal Representatives)

EH-FR-MR-0611-0617-SCLHS

PATIENT INFORMATION

Place label here.
Scanning does NOT work if label is outside this guide.