

PATIENT INFORMATION (This person's health record will be accessible)					
Patient Full Name:					
Date of Birth:					
Address:					
City:	State:	Zip Code:			
Phone:					

Please select the box below that best describes the proxy access requested ***Please Note it may take three business days for your access to be fully granted***

MINOR PATIENT aged 0-17:	ADULT PATIENT				
Individual requesting access will have:	Adult patient to any Adult (18+) Access				
 Full access 	Individual requesting access will have:				
Relationship of Proxy to Patient is:					
Parent Legal Appointed Guardian Legal documents may be required, such as Photo ID, guardianship papers and/or power of attorney. INCAPACITATED/INCOMPETENT ADULT PATIENT Adult patient to any Adult (18+) Access Individuals requesting access will have:	 Full Access – access to view clinical information like test results, medications and sensitive health information, and use messaging and scheduling features; or Clinical Access – access to view clinical information like test results and medication, but no access to messaging or scheduling features; or Schedule & Message Access – access to use messaging and scheduling features, but no access to view clinical information like test results and medications. <i>The above access can be granted by patient without submitting form via the patient's MyChart. Visit TMH.ORG/MyChart for details.</i> 				
 Full access Full access Relationship of Proxy to Patient is: Health Care Surrogate Legal Appointed Guardian Family/Friend/Social Worker Legal documents may be required, such as Photo ID, guardianship papers and/or power of attorney. 					
PROXY INFORMATION (This person will receive access to the above TMH health record – please print)					
Proxy Full Name:					
Proxy Date of Birth:					
Proxy Email Address:					
Proxy Address:					
City: State:	Zip Code:				
Proxy Phone Number:					

Submit Form

TMH HIM Department (Medical Records)



PROXY ATTESTION

By signing below, I acknowledge and agree that:

- I will be using my own TMH MyChart account at TMH to access the Patient's account.
- I will comply with the TMH MyChart Terms and Conditions
- I have parental rights or legal guardianship rights to access this Patient's record (age 0-17).
- At age 18, the Proxy will lose access to the patient's TMH MyChart account & will need to complete a new proxy consent form to gain access.
- There are no court orders or restraining orders in effect limiting my access to this Patient's medical records and/or information.
- I will notify TMH immediately in writing if my legal authority to act on behalf of the patient has been inactivated, revoked, terminated, or expires.
- I am aware that TMH reserves the right to terminate proxy access at any time.
- Communications on behalf of the Patient through the TMH My Chart must be sent from the Patient's record and responses will be received in the Patient's record.
- My Chart e-mail alerts will be sent to the e-mail address entered under Proxy Information.
- Removal of parental proxy access occurs when emancipated minor status is validated.

Proxy Signature	Relationship to Patient	Date	Time
Witness			
ACCESS GRANTED BY CLINICAL STAFF \Box	ACCESS TO BE GRANTED BY COMPLIANCE \Box		

REQUIRED Documentation:
Attached
In Medical Record
Need to Obtain

For Adult-to-Adult Capacitated Proxy Only

- If I choose to grant full proxy access, I understand that my proxy will have full access to my clinical information, which may include sensitive health information, about sexually transmitted infections, alcohol and substance use, HIV/AIDS, behavioral (mental) health, and reproductive health treatment, and genetic information.
- Full access will also enable my proxy to read, send messages and schedule appointments on my behalf.
- Any communications through MyChart made by the authorized individual/proxy will become part of my medical record.
- I understand that I may revoke this access at any time.
- I understand that health information accessed by my proxy may no longer be protected by state or federal privacy laws and could be redisclosed by my proxy.

Patient Signature

Date

Time

Witness_