THE CENTER
ORTHOPEDIC & NEUROSURGICAL CARE & RESEARCH

MYCHART ACCESS AUTHORIZATION FOR ADULT PROXY

Patient information - *All fields are required.*

Patient Name:_____ DOB: _____

Address:_____ Email Address:_____

City, State, Zip:_____ Phone Number: _____

Proxy information - *All fields are required.*

Proxy/Guardian Name:_____DOB:_____

Address: _____ Email Address:_____

City, State, Zip: _____ Phone Number: _____

Relationship to Patient: _____

MyChart Terms and Conditions

I understand the following:

- MyChart contains selected, limited medical information from a patient's medical record and does not reflect the complete contents of the medical record.
- My activities within MyChart are tracked by computer audit, and entries I make can become part of my medical record or the above-named patient's medical record.
- I understand that my access to any information about the patient proxy may be revoked by the patient through a written request.
- If a patient is unable to sign this form, legal documentation must accompany this request listing proxy as power of attorney, legal guardian, or conservator.
- Mail or email this form to: MyChart Team, at 2200 NE Neff Road #200, Bend, OR 97701 mychart@thecenteroregon.com

By signing below, I acknowledge that I am providing documentation of my authorization to access the protected health information of the patient described above. I certify that I am legally authorized to access such information about the patient named above, and that the information I have provided is true and correct.

Proxy signature:_____Date:_____

Proxy printed name:_____

I acknowledge that I have read and understand this MyChart adult proxy form. I agree to its terms and designate the person named above as MyChart proxy, thereby allowing their access to my MyChart medical record.

Patient signature:_____Date:_____

Patient printed name:_____

For Office Use Only

Document to be retained in Patient Record

Patient MRN:_____Proxy Activation Date: _____