

### Adult-Adult MyChart Proxy Access

- A proxy is defined as an authorized individual appointed to view another member's MyChart. Adult-Adult proxy is granted when the member and the proxy are 18 years or older. To activate proxy access, please complete the following steps:
- The proxy completes and signs the *Proxy Information* section on the MyChart Adult Proxy Access Form (see page 2)
- The member who is approving a proxy to view their MyChart records completes and signs the *Member Information* section on the MyChart Adult Proxy Access Form (see page 2) AND the Adult Proxy for Release of Medical Information (see page 3).
- For Legal Guardian Adult Proxy Access, legal documentation is **required** prior to granting proxy access including:
  - Legal Guardian (court order)
  - Power of Attorney for Healthcare (activation)
  - Other: \_\_\_\_\_

Here are just a few of the many features available to MyChart users:

- Access health information online – View a private and personalized health summary and access to your provider's recommended follow-up plan of care
- Check on upcoming appointments – View, cancel or request a visit with your provider
- Manage prescriptions – See current prescriptions details and make refill requests
- Pay bills and view payment history
- Request medical records
- See lab and imaging results – Most results are available within 48 hours
- Track vitals – Use the health trends tools
- Health information library - MyChart links to a library of health information, including health issues, allergies and even medications

MyChart does not display all information from your medical record.. Each web page will describe the information available to you. If you need information or services beyond what is available to you on-line or if you need a complete copy of your medical record, please contact Crossing Rivers Health, Health Information Management Department.

**Note:** Secure messages regarding medical issues will be incorporated in the patient's permanent medical record.

Complete terms and conditions can be found at: <https://mychart.crossingrivers.org/CrossingRivers/>

**Adult-Adult MyChart Proxy Access Form**

**Proxy information:** (All fields required for Adult proxy access – please print clearly).

Name of Proxy (First, Middle, Last): \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

By signing below, I acknowledge that:

- 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 health 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 Medical Records by the patient.
- I understand that my activities within MyChart may be tracked by computer audit and that entries I make may become part of the patient's medical record.
- I understand that access to MyChart is provided by Crossing Rivers Health as a convenience to its patients and that Crossing Rivers Health 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 to authorize a MyChart proxy.
- By signing below, I acknowledge that I have read and understand this MyChart Sign-Up Form and I agree to its terms.

Proxy Signature: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Date: \_\_\_\_\_

**Member information:** (All fields required for Adult proxy access – please print clearly).

Name of Member(First, Middle, Last): \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

By signing below, I acknowledge that:

- I have read and understand this MyChart Sign-up form.
- I agree to its terms and chose to designate the person named above as my MyChart Proxy, thereby allowing them access to my MyChart medical record and have activated my MyChart account.

Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Adult Proxy Authorization for Release of Medical Information**

This form is an authorization that will permit Crossing Rivers Health to release medical and/or health plan information to the member’s designated adult proxy. Please read it carefully.

This form should be completed by the member who is authorizing another adult to access medical and/or health plan information in his/her MyChart record. It must accompany the MyChart sign-up form, which provides the name and the information of the individual who the member is authorizing to access their MyChart records as a proxy. If you need an additional MyChart form, please contact Crossing Rivers Health Information Management Department at Crossing Rivers Health or download one from <https://mychart.crossingrivers.org/CrossingRivers/>

Member Name (First, Middle, Last): \_\_\_\_\_

I am requesting that \_\_\_\_\_ be designated as my MyChart proxy and receive access to my health information and/or health plan information that is available in Crossing Rivers Health MyChart record. This person is designated MyChart proxy. I authorize to release the health information contained in my MyChart record to my MyChart proxy. I understand that the medical and/or health plan information in MyChart is obtained from my electronic medical record. I authorize release of any information contained in my MyChart record held by Crossing Rivers Health to my designated proxy except for sensitive information that is subject to additional, special restrictions or disclosure such as mental health and alcohol or drug abuse treatment information.

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 disclosed information may not be covered by the same federal privacy protections.

Participation in MyChart and designating a MyChart proxy is completely voluntary. I understand that I am not required to designate a MyChart proxy and I am not required to provide this authorization. I also understand that Crossing Rivers Health 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, Crossing Rivers Health is not permitted to provide my designated proxy access to my MyChart record.

This authorization will be effective until terminated by me. I may terminate this authorization at any time by revoking access through my MyChart records or by providing a written request for revocation/cancellation to Crossing Rivers Health, Health Information Management Department, 37868 US Hwy 18, Prairie du Chien WI 53821. I understand that if I revoke or cancel this authorization, my designated proxy’s access to my MyChart record will end. I also understand my revocation/cancellation will not affect any disclosures that were made prior to processing the revocation.

Signature of Member (or legal guardian): \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please mail or fax all forms to:  
Crossing Rivers Health Medical Center  
Health Information Management Department  
37868 US Hwy 18  
Prairie du Chien WI 53821

Fax: 608-357-2277