THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

PATIENT REQUEST FOR OSUMyChart PROXY ACCESS

(Signup form for patient to designate another person's access to the patient's OSUMyChart, or parent/legal guardian to access the patient's OSUMyChart)

If you are 18 years of age or older and would like another adult to access your medical information contained in OSUMyChart, then you, as the patient, should complete this form.

If you are a parent of an unemancipated minor patient or legal guardian of a patient and would like to access the patient's medical information contained in OSUMyChart, then you should complete this form.

Patient's Full Name: _____ Date of Request: _____

Patient's Medical Record Number: _____ Patient's Date of Birth: _____

Patient's Address: Street Address: _____

City: _____ State: _____ Zip: _____

Patient's Telephone Number: Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Name of Proxy: _____

Proxy's Date of Birth: _____

Proxy's Address: Street Address: _____

City: _____ State: _____ Zip: _____

Proxy's Telephone Number: Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Proxy's E-Mail Address: _____

Proxy's Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Other Adult

Has the proxy ever been a patient at the OSU Wexner Medical Center or Madison County Hospital? ☐ Yes ☐ No ☐ Don't Know

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Please Read Carefully.

I understand that medical information is contained in OSUMyChart. This may include providers covered in the Joint Notice of Privacy Practices.

I know that any information that is in OSUMyChart could be shared by my proxy with others. I know theremay not be laws that protect my privacy in this case.

I know that signing this form only gives my proxy access to information in OSUMyChart. I would need to givemy permission for release of my full medical record or paper copies.

I know it is my choice to use OSUMyChart and have a proxy.

I know that my care and services at OSU Wexner Medical Center or Madison County Hospital will not change based on whether or not I sign up to have a proxy.

I know that this proxy access does not grant legal representation for my health care.

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I hereby authorize The Ohio State University Wexner Medical Center, including healthcare providers listed in the Joint Notice of Privacy Practices, and its employees to release the information contained in OSUMyChart. I understand and acknowledge that this authorization may include treatment for physical and mental illness, alcohol and/or drug abuse, and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include results of an HIV test or the fact that an HIV test was performed. A separate authorization is required for the release of psychotherapy notes. I expressly consent to the release of information contained in OSUMyChart. This authorization is valid for 365 days, unless revoked by my written notice, provided said notice is received prior to release of information contained in OSUMyChart. **The revocation of this authorization is effective except as indicated in The Ohio State University Health System's Joint Notice of Privacy Practices. Information released by this authorization may no longer be protected by federal privacy rules, such as HIPAA**. I understand that The Ohio State University Wexner Medical Center and Madison County Hospital cannot condition my treatment or payment for health care on this authorization unless the treatment is research-related or the care was provided solely to provide information for a third party.

I know that I can stop or change my proxy access at any time. I can stop access through OSUMyChart or by sending a written request to: The Ohio State University Wexner Medical Center, Medical Information Management Department-Attn: ROI Manager, 600 Ackerman Rd. Columbus, Ohio 43202.

I understand that this form will be in effect for one year from the date it is signed. I must sign a new proxy form each year I want to give another person access to my information in OSUMyChart or I must renew the proxy's access yearly through OSUMyChart.

NOTE: Only two people can have proxy access to your information in OSUMyChart. For example, you may grant proxy access to your spouse and a sibling.

_____	_____
Signature of Patient or Person Authorized to Consent	Date Signed
_____	_____
Relationship, if not the patient	Date Signed
_____	_____
Witness (Optional)	Date Signed

For Clinic Office Staff Only

Name of Clinic: _____

Office Associate's Name Confirming Identity of Person Completing Form: _____

Office Associate's Contact Number: _____

Date Scanned: _____

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