



To the Requesting Proxy,

To request access to the MyChart record of a patient whose medical care you help manage, please complete this form. Completing this form will establish a MyChart record for you and for the patient. In order to ensure that MyChart is a secure way to view portions of a patient's personal medical information, we require three (3) identifiers to grant proxy access. The identifiers are:

- A MyChart access code (provided by Inova or Valley Health);
- The proxy's date of birth; and
- The proxy's FULL Social Security Number.

Please enter the proxy's FULL Social Security Number:

_____ - _____ - _____ and complete pages 1 and 2 of this form **(REQUIRED)**.

Upon completion of your request, this cover sheet will be shredded in an effort to protect from any misuse. Pages 1 and 2 will be retained in the permanent medical record.

You (the proxy) will access the patient's account through your own MyChart account. If you (the proxy) do not have a MyChart account, one will be created.

Inova and Valley Health workforce members are prohibited from using or disclosing Social Security Numbers for any purpose other than legitimate healthcare operations or business functions. Inova and Valley Health align with leading technology and standards in the healthcare industry to protect your confidential information.

PLEASE NOTE: The patient must sign this form and provide authorization for release of medical information in MyChart on the Patient Proxy MyChart Authorization on page 2. If the patient is not capable of signing, we require proper legal documentation of proxy's authority to make that decision in order to grant proxy access.

DO NOT SCAN

**** This page MUST be SHREDDDED. It is not part of the permanent medical record. ****



You may request access to another patient's MyChart record in limited circumstances, including for patients whose medical care you manage such as a spouse, adult child (above the age of 18), or parent. To request access to the MyChart record of a patient whose medical care you help manage, please complete this form. **Upon completion return this form to Inova or Valley Health Staff.** Access to this patient's MyChart record will be provided only after approval by Inova or Valley Health. Upon approval, this form will authorize Inova or Valley Health staff to designate proxy access in Epic and establish a MyChart record both for you and for the patient. Please note that the patient's chart will be accessed through your (the proxy's) MyChart record

Proxy's Information (All sections required - please print clearly)

This section should be completed by the individual requesting access to another patient's MyChart record. *

Name (last, first, middle initial) _____ Date of Birth: _____
 Phone Number: _____ Email: _____
 Street Address: _____ City: _____ State: _____ Zip: _____

Proxy's Relationship to Patient:

____ Parent _____ Caregiver for Adult Patient
 ____ Spouse _____ Personal Representative
 ____ Durable Power of Attorney for Healthcare (DPOA) * _____ Other (specify) _____
 ____ Legal Guardian **

Patient's Information

This section should be completed by the patient authorizing another individual to access medical information in his or her MyChart record. *

- This form is an authorization that will permit Inova or Valley Health to release your medical information to your designated patient proxy. Please read it carefully. This form should be completed by the person who is authorizing another person to access medical information in his or her MyChart record. It must accompany the Patient Proxy Form, which provides the name and information of the individual who the patient is authorizing to access their MyChart record as a proxy.
- I am requesting that _____ (insert name of proxy) receive access to my health information that is available in my Inova or Valley Health MyChart Record. This person is my designated MyChart proxy. I authorize Inova or Valley Health System to release the health information contained in my MyChart record to my MyChart proxy. I understand that the medical information in MyChart is obtained from my electronic medical record and may include information from all Inova facilities.
- 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 state or 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 Inova or Valley 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, Inova or Valley Health is not permitted to provide access to my MyChart record to my designated proxy.
- This authorization will not expire and will remain in effect until I revoke such authorization. I may revoke this authorization at any time electronically through my MyChart account. I understand that if I revoke this authorization, my designated proxy's access to my MyChart record will be ended. I also understand my revocation will not affect any disclosures that were made prior to processing the revocation request.

* Proper ID must be validated and scanned with this application

** This request must be accompanied by a copy of proper legal documentation verifying the patient's personal representative

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

**Inova
Valley Health
MyChart Proxy Form - Adult**

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MyChart Terms and Agreement

- I understand that MyChart is intended as a secure online source of confidential medical information. I understand that the sharing of my MyChart ID and password is strongly discouraged as it may compromise personal medical information. If I were to share my MyChart ID and password with another person, that person may be able to view mine or my spouse, or adult child's health information, as well as the health information of anyone who may have authorized me as a MyChart proxy. Inova and/or Valley Health are not liable for any breach of privacy that may result from such sharing.
- 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 Health Information Management (Medical Records Department).
- 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 Inova and Valley Health as a convenience to their patients and that Inova and Valley Health have 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 the MyChart terms and conditions and I agree to all terms.

REQUIRED: Proxy (signature) **Proxy** (print name) Relationship to Patient Date/Time

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

REQUIRED: Patient or Designated Decision **Patient or Designated Decision Maker** (print name) Date/Time
Maker (signature)

If Designated Decision Maker signs, indicate authority to sign for patient (e.g., guardian) and attach proper legal documentation:

Proxy access will NOT be granted without proper legal documentation.

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

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