

This form is an authorization that will permit providers utilizing The Queen's Health Systems (QHS) Electronic Health Record (EHR) system to release your medical information in your MyChart to your designated adult proxy. Please read it carefully.

This form should be completed by the patient who is authorizing another adult to access medical information in his or her MyChart record. It must accompany the Adult Proxy Request Form, which provides the name and information of the individual who the patient is authorizing to access their MyChart record as a proxy. If you do not have an Adult Proxy Form, please contact your clinic or provider, or download one from <https://mychart.queens.org>

Patient Name (*last, first, middle initial*) _____

Last 4 digits SSN: _____ Date of Birth: _____

I authorize _____ (*insert name of proxy*) access to my health information that is available in my MyChart powered by Queen's. This person is my designated MyChart proxy. I understand that the medical information in MyChart is obtained from my electronic medical record and may include information from all facilities, clinics and providers participating with MyChart powered by Queen's.

I authorize release of all health information contained in my MyChart to my designated proxy; including any of the following information should it be contained in my MyChart: Acquired Immune Deficiency Syndrome (AIDS), ARC or HIV, alcohol and/or drug abuse treatment and/or behavioral or mental health services. I understand that this authorization applies only to the release of the information through my MyChart. 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 to my proxy through MyChart, it may be re-disclosed by the proxy and no longer protected by federal privacy regulations.

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 QHS and my providers will not condition any of my health care treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.

This authorization will expire automatically one year from the date of my signature. I understand that I may revoke this authorization at any time by providing a written request for revocation to Medical Records at The Queen's Medical Center (1301 Punchbowl Street Honolulu, HI 96813). I understand that if I revoke this authorization, my designated proxy's access to my MyChart record will be ended within 5 business days of receipt of the revocation request. I also understand my revocation will not apply to any information that was already disclosed in reliance on this authorization.

Signature of Patient (or Personal Representative)

Date of Signature

Printed Name: _____

If person other than the patient signs, indicate authority to sign for patient (e.g., guardian) and attach documentation:

NOTE: Authorization expires one year from the date of signature (above). A new *MyChart Proxy Authorization Form* must be submitted each year to renew proxy access. You also may deactivate the access of the adult proxy specified above at any time through MyChart or by providing a written request to QMC Medical Records.

