Children's Hospital of Wisconsin

MyChart Adult Proxy Authorization Release of Information Form

This form is an authorization that will permit Children's Hospital of Wisconsin (CHW), their affiliated clinics, entities, and other providers who use the CHW electronic medical record to release your medical information to your designated adult proxy.

Your Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

I understand that:

- Authorizing proxy access will allow the person named below access to my personal health information through MyChart. This form does not authorize release of my medical records to my designated proxy by other methods or in other forms.
- If I no longer wish this individual to access my information, it is my responsibility to revoke their access.
- A written request must be made to revoke this proxy access, and any actions taken or accesses made prior to that revocation were authorized as part of the initial signature and date.
- All activities within my MyChart account may be tracked by computer audit, and entries my proxy makes may become part of my medical record.
- Access to a MyChart account is provided as a convenience, and access to my MyChart account may be revoked at any time for any reason, including unauthorized or inappropriate actions made by my proxy.
- Use of my MyChart account is voluntary, and I am not required to use MyChart or to authorize another person (proxy) to access my MyChart account.
- The authorization permits access to any care provided to the date of the authorization as well as any care and treatment provided while the authorization is valid.
- While CHW has taken efforts to remove sensitive information from MyChart, there may be sensitive information available in MyChart. This means my proxy will have access to records that may include information relating to the diagnosis and/or treatment of mental illness, alcohol/drug abuse, STD's, HIV test results, adolescent health, developmental disabilities and genetic testing results.
- Once information has been disclosed, the proxy may further disclose my health information and it may no longer be protected by federal health law.
- By signing below, I acknowledge that I have read and understand the authorization, and I agree to its terms and grant proxy access to my personal health information via MyChart to the individual named below.

Proxy Name/Relationship: _____ Proxy Date of Birth: _____

Proxy Address: _____ Proxy Phone Number: _____

Patient Signature: _____ Date: _____