# HOAG CONNECT MYCHART PROXY ACCESS FORM - ADULT
## Proxy Access to Hoag Connect MyChart

**Patient Information: (Completion of all sections required - please print clearly)**

Medical Record Number: _____

Patient's Name (last, first, middle initial): _____

Date of Birth: _____

Phone: _____

Email Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

**Proxy Information: (Completion of all sections required - please print clearly)**

In order to view the Patient's information, the Proxy must also obtain their own Hoag Connect MyChart account.

Proxy's Name: _____ Date of Birth: _____

Phone: _____

Email Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Please check one box next to the appropriate access to be granted to the proxy:

- ☐ view record, send messages, and schedule appointments (full access)
- ☐ send messages and schedule appointments
- ☐ view record only

## Terms and Conditions for Granting/Receiving Proxy Access

1. I have read, understand and agree to the requirements and procedures for accessing medical information through the Hoag Connect MyChart application as provided in the Hoag Connect MyChart Terms and Conditions of Use which can be reviewed online.
2. I understand that by granting proxy access, I am allowing the proxy access to the contents of my Hoag Connect MyChart record. I understand that granting proxy access is completely voluntary.
3. I understand that the medical information included in Hoag Connect MyChart may include medical information considered very personal, including information about sexually transmitted and other communicable diseases, drug and alcohol abuse, HIV/AIDS, and mental health services. My health care provider, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
4. I understand that access to Hoag Connect MyChart is provided as a convenience to patients and that Hoag has the right to deactivate my access or my proxy's access at any time for any reason or for no reason.
5. I understand that this authorization will continue until revoked. I understand that I may revoke this consent at any time in Hoag Connect MyChart or may contact Hoag to have a proxy's access revoked.
6. I understand that it is my responsibility to terminate my proxy's access to my Hoag Connect MyChart account if I no longer wish to allow him/her access to my Hoag Connect MyChart information. Termination of proxy access is not immediate. Hoag will use its best efforts to terminate your proxy's access within ten (10) business days of receiving a written request.
7. I understand that for all medical emergencies, I need to immediately dial 911.
8. I authorize the Use or Disclosure of Electronic Protected Health Information.

By signing below, I acknowledge that I have read, understand and agree to this Hoag Connect MyChart Adult Proxy Access form, the terms and conditions for Hoag Connect MyChart.

Signature of Patient or Legal Representative: _____ Date/Time: _____

If signed by other than patient, indicate relationship: _____

Print Name (Legal Representative): _____

Please allow 5-10 business days for processing. You or your proxy will receive a letter with the access code. The access code will be valid for 14 days. You will need the access code to log into the account. It should not be shared with anyone.

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Processed by: _____ Date: _____ Time: _____



PATIENT LABEL