

Adult Caregiver/Proxy & ROI Form

- Fill out this form if your Caregiver/Proxy is NOT an ARC patient. Instructions below.
- If you and your adult Caregiver/Proxy already have active ARC MyChart accounts, visit ARCmychartproxy.com for guided instructions.

INSTRUCTIONS:

This MyChart Adult Caregiver/Proxy & Release of Information (ROI) authorization form will permit Austin Regional Clinic to release the health information contained in your ARC MyChart record to your Adult Caregiver/Proxy as designated below.
***** Please read it carefully. *****

This form should be **completed by the patient authorizing another adult to access his or her medical information** in their ARC MyChart record. Completing this form will establish an ARC MyChart account for you and your caregiver/proxy.

1. Complete Form

PATIENT'S INFORMATION: *****ALL FIELDS REQUIRED***** Please print clearly.

Last Name of Patient: _____ First Name: _____ Middle Initial: _____
ARC Medical Record Number (acquire at clinic): _____ Date of Birth: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Email Address: _____ Best Phone Number: _____
Primary Clinic: _____

CAREGIVER/PROXY INFORMATION: *****ALL FIELDS REQUIRED***** Please print clearly.

Last Name: _____ First Name: _____ Middle Initial: _____
Non-ARC Patient – Last Four Digits of Your Social Security Number: _____ Date of Birth: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Email Address: _____ Best Phone Number: _____

2. Sign MyChart ROI Terms and Agreement

I am requesting that the Caregiver/Proxy listed above receive access to my health information that is available in my Austin Regional Clinic MyChart Record. This person is my designated MyChart Caregiver/Proxy. I authorize Austin Regional Clinic to release the health information contained in my MyChart record to my MyChart Caregiver/Proxy indicated above. I understand that the medical information in MyChart is obtained from my electronic medical record and may include information from all facilities listed in Austin Regional Clinic's Notice of Privacy Practices. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I authorize release of any information contained in my MyChart medical record held by Austin Regional Clinic to my designated Caregiver/Proxy.

I authorize release of this information only through my MyChart record. This form does not authorize release of my medical record to my designated Caregiver/Proxy by other methods or in other forms.

I understand that once information has been disclosed, it potentially may be re-disclosed by the Caregiver/Proxy and the disclosed information may not be covered by federal privacy protections.

Participation in MyChart and designating a MyChart Caregiver/Proxy is completely voluntary. I understand that I am not required to designate a MyChart Caregiver/Proxy and I am not required to provide this authorization. I also understand that Austin Regional Clinic 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, Austin Regional Clinic is not permitted to provide access to my MyChart record to my designated Caregiver/Proxy.

***** Flip to complete page 2 of this form *****

Adult Caregiver/Proxy & ROI Form

(Terms and Agreement continued)

I may revoke this authorization at any time. I understand that if I revoke this authorization, my designated Caregiver/Proxy's access to my MyChart record will end but that my revocation does not apply to information already accessed in MyChart in reliance on my authorization. Any patient aged 12 and over can revoke Caregiver access through their MyChart Account under My Account > My Family's Records. I understand any revocation will not affect any disclosures that were made prior to revoking Caregiver/Proxy access.

I acknowledge that I have read and understand this MyChart Adult Caregiver/Proxy & ROI authorization form. I hereby affirm I am the patient and Caregiver/Proxy identified above. I agree to its terms and choose to designate the person named above as my MyChart Caregiver/Proxy, thereby allowing them access to my MyChart medical record. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

By signing below, I acknowledge that I have read and understand this MyChart Adult Caregiver/Proxy & ROI authorization form and I agree to its terms.

Signature of Caregiver	Relationship to Patient	Date <i>(required)</i>
Signature of Patient/Authorized Person		Date <i>(required)</i>
If person other than the patient signs, indicate authority to sign for patient (<i>e.g., guardian, power of attorney</i>) and attach documentation:		

NOTE: Authorization is indefinite and will remain active until such a time as you deem necessary to deactivate the access of the caregiver/proxy specified above by providing a written request to your primary clinic.

3. Submit Completed Form

Return the completed form to the front desk at your ARC clinic.

FOR CLINIC USE ONLY:

Please sign and date processed forms prior to forwarding to Centralized Scanning.

Approved by: _____ Clinic Location: _____ Date: _____

Proxy granted by: _____ Department Name: _____ Date: _____