



LABEL

Proxy Access Form

Access to a patient's or Avera Health Plan Member's Avera MyChart

To request access to the Avera MyChart record of a patient or member whose medical care and/or health insurance matters the proxy helps manage, please complete this form. Completing this form establishes an Avera MyChart for the proxy and for the patient. Please note, the proxy accesses the patient's records through the proxy's access. Each individual and/or proxy must complete a separate form. Please allow approximately seven (7) business days to establish proxy access. After proxy access is established, you get an email to the address provided. Click on the link in the email to gain access to Avera MyChart.

Patient/Member Information

Completed by the individual granting Avera MyChart proxy access.

** Required Fields.*

*Name (last, first, middle name): _____ *Date of Birth: _____ *Gender: _____

Last 4 digits of SSN: _____ *Phone Number: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Proxy Information

Completed by the individual requesting access to a patient's Avera MyChart.

** Required Fields.*

*Name (last, first, middle name): _____ *Phone Number: _____

Street Address: _____ City: _____ State: _____ Zip: _____

*E-mail: _____

If you are a patient at an Avera MyChart facility and would also like access to your own record, please provide us with:

*Date of Birth: _____ *Gender: _____

Authority of Proxy

_____ Patient is an incapacitated person and I am the patient's guardian. See the attached paperwork which is still in effect.

_____ The patient authorized me to access their medical record information. See Patient section below.

_____ Other: _____

Avera MyChart terms and agreement

- I understand that Avera MyChart is intended as a secure online source of confidential medical and/or health insurance information.
- If I share my Avera MyChart ID and password with another person, that person may be able to view any health information to which I have access through Avera MyChart.
- 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 Avera MyChart contains selected, medical information from a patient's medical and/or health insurance record and that Avera MyChart does not reflect the complete record.
- I understand that my activities within Avera MyChart may be tracked by computer audit and that entries I make may become part of the patient's medical and/or health insurance record.
- I understand that access to Avera MyChart is provided as a convenience to its patients and members and that access to Avera MyChart may be deactivated at any time for any reason. I understand that use of Avera MyChart is voluntary and I am not required to use Avera MyChart or to authorize an Avera MyChart proxy.



PROXACC

LABEL

Proxy Access Form**Proxy:**

I acknowledge and agree that:

- The patient and/or member can revoke the proxy access to his/her Avera MyChart at any time.
- I will comply with the terms and conditions on Avera MyChart and this document.
- When my legal authority to act on behalf of the patient and/or member has been inactivated, revoked, terminated or expired, I must immediately notify Avera MyChart in writing of the revocation, termination or expiration and deliver it to Avera Health, Attn: Release of Information, or AHROI@Avera.org, or fax 605-322-8200.

► _____ / _____ / _____
Proxy Signature Relationship to Patient and/or Member Date

Patient and/or Member:

I acknowledge and agree that:

- I will comply with the terms and conditions on Avera MyChart and this document.
- I choose to designate the person named above as a proxy to my Avera MyChart, thereby allowing him/her access to Avera MyChart protected health information, including but not limited to, behavioral health records, and HIV/AIDS test results. I authorize release of any information contained in my Avera MyChart medical record held by health facilities utilizing Avera MyChart (a list of facilities can be found at Avera.org/MyChart) to my designated proxy. I understand that the medical information in Avera MyChart is obtained from my electronic medical record and may include information from all facilities listed in the health facilities' Notice of Privacy Practices.
- I authorize the release of any health insurance information related to my Avera Health Plans coverage, including, but not limited to, claims and benefits details and billing information.
- I authorize release of this information only through my Avera MyChart record. This form does not authorize release of my medical record to my designated proxy other than through the Avera MyChart.
- 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 federal privacy protections.
- Participation in Avera MyChart and designating an Avera MyChart proxy is completely voluntary. I understand that I am not required to designate an Avera MyChart proxy and I am not required to provide this authorization. I also understand that the healthcare facility or Avera Health Plans does not condition any of my health care treatment, payment, coverage or other services on whether I provide this authorization.
- I understand that if I no longer want the proxy to have access to my Avera MyChart, I may revoke his/her access in writing by sending a request to my Avera facility to the attention of Health Information Management. A Proxy Revocation form may also be found at Avera.org/MyChart.
- I understand that if I revoke this authorization, my designated proxy's access to my Avera MyChart will be ended. I also understand my revocation will not affect any disclosures that were made prior to processing the revocation request.
- Unless proxy access is deactivated or otherwise revoked by patient or patient's legally authorized representative, access shall be granted to proxy until termination of patient's and/or member's Avera MyChart.

► _____ / _____ / _____
Patient and/or Member Signature Relationship to Proxy Date

► _____ / _____ / _____
Signature of Legal Representative Relationship to Proxy Date

Patient and/or member signature not required when patient and/or member or proxy has legal authority. Please attach relevant document(s).

Return forms to:
Your health facility
Attn: Release of Information
email: AHROI@Avera.org
Fax: 605-322-8200

HIM use only (staff initials)

____ Patient signature verified
____ Approved by HIM
____ Proxy access granted
____ Form scanned into medical record