

## Adult Proxy Access to the Online MyChart of a patient Age 18 or older

### Requirements and Procedures

Proxy access for adult patients allows another person, of the patient's choosing, to log into their personal MyChart account, and then connect to information regarding the patient. Patients over 18 will be required to sign the Adult Proxy form granting permission for the Delegate to access their medical record. Both the patient and the Delegate must sign and return the Adult Proxy Authorization Form prior to access being granted.

Requirements for Proxy online access to a patient's record:

- Individual requesting access must have a signed consent from the patient
- Adult Proxy Access Authorization Form must be completed and signed
- Each Delegate requesting access must have their own MyChart account

I understand that:

- I must have a MyChart account
- I must log in to MyChart with my own User ID & Password
- I must click on 'My Family's Records' to access a patient's online record
- I agree to abide by the terms and conditions on the MyChart site
- **MyChart is not to be used in an emergency**

Adult Proxy access to a patient's record will be revoked upon the patient's written request. Ann & Robert H. Lurie Children's Hospital of Chicago and/or your independent physician practice reserves the right to revoke online access to medical information at any time.

Communications on behalf of the patient must be sent from the patient's record; responses will be posted in the patient's record. MyChart e-mail alerts will be sent to the e-mail address entered in the patient's record.

If you already have a MyChart account, you will receive a letter notifying you that access to the patient's record is available, typically 5-7 business days. You will be granted access only after the completed Adult Proxy Authorization form is received.

If you do not have a MyChart account, upon submitting your electronic request a MyChart Activation Letter with Access Code and instructions will be mailed to you typically in 5-7 business day. Access to MyChart will be granted upon Lurie Children's or your independent physician practice receiving the completed Parent/Guardian Authorization form. If you do not activate your account within 60 days after receiving your MyChart Activation Letter, your account will be inactivated.

### Adult Proxy Authorization Form

Please enter **Patient's** information below:

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Gender: \_\_\_\_\_ Male \_\_\_\_\_ Female

**To be notified when new messages about the patient's care are sent to MyChart, please list an email address:** \_\_\_\_\_

Please enter **Delegate** information below:

Delegate Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Gender: \_\_\_\_\_ Male \_\_\_\_\_ Female

Relationship to patient: \_\_\_\_\_ Parent \_\_\_\_\_ Spouse \_\_\_\_\_ Other

If Other, please specify: \_\_\_\_\_

Do you have an active MyChart account? \_\_\_\_\_ Yes \_\_\_\_\_ No

**I have read and understand the requirements and procedures regarding accessing a patient's medical record information online as provided on the document titled Adult Proxy Access to the Online Medical Record of a MyChart Patient.**

**I certify that I am a Delegate of the above named patient and all information I have provided is correct. I hereby request access to this patient's online medical record.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Delegate Signature

I agree to allow the delegate, named above, online access to my medical information currently available and that may become available as a result of future medical care. I understand I may revoke this access at any time.

I understand that the following items may be disclosed along with other health information in my medical record: HIV/AIDS related health information and/or records, behavioral or mental health information and/or records, information about sexually transmitted disease (STD), pregnancy, birth control, drugs/alcohol diagnosis, treatment, and/or referral information, genetic testing information and/or records, information about sexual assault/abuse, information about child abuse and neglect, and domestic abuse of an adult with a disability.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

**Please send this completed form via postal mail or fax to your child's primary clinic location.**

**Ad-Park Pediatric Associates**

1640 W Lake St, Suite 200  
Addison, IL 60601  
Fax: 630-543-1551

610 S Maple Ave, Suite 3150  
Oak Park, IL 60304  
Fax: 708-383-7498

**Children's Gastroenterology Specialists**

3633 W Lake Ave, Suite 103  
Glenview, IL 60026  
Fax: 847-724-7845

**Elm Street Pediatrics**

572B Lincoln Ave  
Winnetka, IL 60093  
Fax: 847-501-4075

**Fairview Pediatrics**

1475 E. Belvidere Rd, Suite 215  
Grayslake, IL 60030  
Fax: 847-548-8899

**Highland Park Pediatric Associates**

1160 Park Ave West, Suite 3E  
Highland Park, IL 60035  
Fax: 847-432-9480

**Lake Shore Pediatrics**

900 N. Westmoreland Rd, Suite 106  
Lake Forest, IL 60045  
Fax: 847-615-0730

27790 W. Hwy 22, Suite 36  
Barrington, IL 60010  
Fax: 847-381-4602

1800 Hollister Dr, Suite 220  
Libertyville, IL 60048  
Fax: 847-362-4615

**Pediatric Associates of Barrington**

912 W. Northwest Hwy, Suite G-7  
Fox River Grove, IL 60021  
Fax: 847-381-6828

260 Congress Pkwy, Suite B  
Crystal Lake, IL 60014  
Fax: 815-459-1648

**Pediatric Partners**

300 Center Dr, #103  
Vernon Hills, IL 60061  
Fax: 847-362-4425

767 Park Ave West, Suite 230  
Highland Park, IL 60035  
Fax: 847-681-7110

**Premier Pediatrics**

185 N. Milwaukee Ave, Suite 220  
Lincolnshire, IL 60069  
Fax: 847-821-9501

36100 Brookside Dr, Suite 204  
Gurnee, IL 60031  
Fax: 847-821-9501

**Wheaton Pediatrics**

1725 S. Naperville Rd, Suite 100  
Wheaton, IL 60189  
Fax: 630-690-7335

725 W Fabyan Pkwy, Suite B  
Batavia, IL 60510  
Fax: 630-690-7335

**Woodfield Pediatrics**

1345 Wiley Rd, Suite 117  
Schaumburg, IL 60173  
Fax: 847-884-1113