

FORM C

**SPARTANBURG REGIONAL HEALTHCARE SYSTEM
PATIENT REQUEST FOR MYCHART PROXY ACCESS
AUTHORIZATION FORM
ADULT PATIENT**

Please print, fill out and return all Proxy Access forms to the patient's designated physician practice.

Patient's Name: _____ Patient's Current Street Address: _____
Patient's Telephone #: _____
Patient's Date of Birth (mm/dd/yy): _____
City State Zip Code

PATIENT REQUEST TO DESIGNATE A MYCHART PROXY

For the purposes of this form, "you," "your," "my," and "I" mean the patient listed above whose record is maintained by SRHS. I hereby authorize the individual designated below ("MyChart Proxy") to act on my behalf regarding any and all of my health information contained in SRHS MyChart, which shall include, but not be limited to, receiving access to SRHS MyChart functions which allow my MyChart Proxy to view, download, and/or transmit to third parties any and all of my health information, according to the SRHS MyChart Proxy Terms and Conditions. As such, I hereby authorize SRHS to release via SRHS MyChart Proxy Access any and all of my health information contained in SRHS MyChart to my MyChart Proxy for any purpose that my MyChart Proxy deems to be appropriate. I understand and acknowledge that this may include information relating to treatment for physical and mental illnesses, alcohol/drug abuse, and/or HIV/AIDS test results or diagnoses.

Once your health care information is released, your information may be re-disclosed by the recipient and may no longer be protected by law. Treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether you agree to this authorization. In order for this authorization to be valid, activation of the SRHS MyChart Proxy access feature must occur within one (1) year of the date of this authorization. Upon receipt of this completed form, please allow approximately seven (7) business days for processing your request to designate a MyChart Proxy.

This authorization for the MyChart Proxy's access to my SRHS MyChart account will automatically expire when SRHS receives notice of my death, when I (or my legal representative) deactivate(s) my SRHS MyChart account or when I (or my legal representative) revoke(s) this authorization, whichever occurs first. You may revoke this authorization at any time, except to the extent that action has been taken in reliance upon it, through written notice sent to the designated physician practice.

MyChart Proxy's Name (Print)

MyChart Proxy's Email #

MyChart Proxy's Date of Birth

MyChart Proxy's Telephone Number

MyChart Proxy's Gender

MyChart Proxy's Address

Signature of Patient

Date