

TO BE COMPLETED BY PROXY (INDIVIDUAL REQUESTING ACCESS):

Name:		Social Security #:
Address:		
Email:	Phone:	Date of Birth:
<p>I have read and understand the requirements and procedures regarding proxy access above. All information I have provided is correct. I understand that:</p> <ul style="list-style-type: none"> • I must have a Baptist Health MyChart account to obtain proxy access to another patient's account. • I must log in to Baptist Health MyChart with <u>my own</u> User ID & Password when utilizing proxy access, and will obtain proxy access from my account. • I agree to abide by the Baptist Health MyChart Terms and Conditions. • Baptist Health reserves the right to revoke proxy access to a Baptist Health MyChart account at any time. • Baptist Health MyChart is not to be used to communicate or obtain treatment in an emergency. <p>I am requesting proxy access for the patient identified below and I certify that (check one box, as applicable):</p> <p><input type="checkbox"/> I am the Patient's Health Care Power of Attorney</p> <p><input type="checkbox"/> I am the Patient's (circle one): Father / Mother / Legal Guardian</p> <p><input type="checkbox"/> I am the Patient's family/caregiver (describe any family relationship: _____).</p> <p><input type="checkbox"/> Other (describe relationship): _____</p> <p>Signature of Proxy: _____ Date: _____</p>		

TO BE COMPLETED BY/FOR THE PATIENT:

Name:		Date of Birth:
Address:		
Social Security #:	Male: _____	Female: _____
<p>The undersigned grants proxy access to his/her Baptist Health MyChart record to the person requesting proxy access listed above. Or, for a minor patient or incompetent patient, the undersigned grants proxy access to the patient's Baptist Health MyChart record on behalf of the patient to the person requesting proxy access listed above. This form must be signed by the patient if a competent adult or a minor over 13 years of age.</p> <p>By checking this box, you agree that your electronic signature is the legal equivalent of your manual signature on this document</p> <p>Signature of Patient (or Representative/Guardian/Parent): _____ Date: _____</p> <p style="text-align: center;">Submit Form via Email</p>		

**Please submit completed form to via mail/email :

Baptist Health Release of Information
 2600 Stanley Gault Pkwy. Suite 101
 Louisville, Ky. 40223
 Phone: 502-253-4828
 Email: BaptistPHRQuestions@BHSI.com