

**TO BE COMPLETED BY PROXY (INDIVIDUAL REQUESTING ACCESS):**

<b>Name:</b>		<b>Social Security #:</b>
<b>Address:</b>		
<b>Email:</b>	<b>Phone:</b>	<b>Date of Birth:</b>
<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"> <li>• I must have a Baptist Health MyChart account to obtain proxy access to another patient's account.</li> <li>• I must log in to Baptist Health MyChart with <u>my own</u> User ID &amp; Password when utilizing proxy access, and will obtain proxy access from my account.</li> <li>• I agree to abide by the Baptist Health MyChart Terms and Conditions.</li> <li>• Baptist Health reserves the right to revoke proxy access to a Baptist Health MyChart account at any time.</li> <li>• <b>Baptist Health MyChart is not to be used to communicate or obtain treatment in an emergency.</b></li> </ul> <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><b>Signature of Proxy:</b> _____ <b>Date:</b> _____</p>		

**TO BE COMPLETED BY/FOR THE PATIENT:**

<b>Name:</b>		<b>Date of Birth:</b>
<b>Address:</b>		
<b>Social Security #:</b>	<b>Male:</b> _____	<b>Female:</b> _____
<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. <b>This form must be signed by the patient if a competent adult or a minor over 13 years of age.</b></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><b>Signature of Patient (or Representative/Guardian/Parent):</b> _____ <b>Date:</b> _____</p> <p style="text-align: center;"><b>Submit Form via Email</b></p>		

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

**Baptist Health Release of Information**  
 2600 Stanley Gault Pkwy. Suite 101  
 Louisville, Ky. 40223  
 Phone: 502-253-4820  
 Email: BaptistPHRQuestions@BHSI.com