



Cheyenne Regional

MyChart Proxy Adult to Adult Request

Health Information Management
Cheyenne Regional Medical Center
2600 E 18th Street Cheyenne, WY 82001;
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Email: CheyenneRegionalHIM@crmcwy.org

Proxy Information:

Name of Proxy _____
(print last, first, middle initial)

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

DOB: ____/____/____ Phone Number: _____

You are Requesting Proxy Access:

Please note that for all types of proxy access, the patient's chart must be accessed through your *MyChart* account. If you do not currently have a *MyChart* account, please provide your social security number: _____/_____/_____ and a *MyChart* account will be created for you as part of this proxy request.

You will have access to your account as well as proxy access as requested below.

Adult-Adult (Access to another adult's MyChart record)

The patient must sign this form and provide authorization for release of medical information in MyChart on the "Adult Proxy Authorization Form for Release of Information".

Adult Patient's Information: (All fields required for Adult proxy access – please print clearly.)

Complete this section with information about the adult patient whose *MyChart* record you're requesting to access.

Name: _____ Date of Birth: _____
(print last, first, middle initial)

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

Clinic: _____

MyChart Terms and Agreement

- I understand *MyChart* is intended as a secure online source of confidential medical information. If I share my *MyChart* ID and password with another person, that person may be able to view my or my proxy's health information, and health information about someone who has authorized me as a *MyChart* proxy.
- 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 confidentiality may have been compromised in any way.
- I understand it is my responsibility to ensure that my e-mail address is current at all times, and if my e-mail address is not current, I will not receive important messages from *MyChart*.
- I understand that *MyChart* contains selected, limited medical information from a patient's medical record and *MyChart* does not reflect the complete contents of the medical record. I also understand the patient or proxy may request a paper copy, a disc copy or an upload to *MyChart* of his/her medical record from the Health Information Department.
- I understand my activities within *MyChart* may be tracked electronically and entries I make may become part of the medical record.
- I understand access to *MyChart* is provided as a convenience to patients and access to *MyChart* may be deactivated at any time, for any reason.

For MyChart Sign-up and all Types of Proxy Access:

By signing below, I acknowledge that I have read and understand this *MyChart* Sign-Up Form and I agree to its terms.

_____/_____/_____
Your Signature Relationship to Patient Date (Required)

If Legal Guardian/Power of Attorney is being used, a copy of the documentation must accompany this request.

For Adult Proxy Access:

I acknowledge that I have read and understand this *MyChart* Sign-up form. I agree to its terms and choose to designate the person named above as my *MyChart* Proxy, thereby allowing them access to my *MyChart* medical record.

Patient signature _____/Date _____

