MyChart PROXY ACCESS TERMINATION FORM
(Proxy access to the MyChart record of another adult 18 years of age or older or of a teenaged minor 13-17 years of age)

PATIENT INFORMATION – all fields are required

Name: ______________________________ Date of Birth: ______________

Street Address: ______________________________ City/State: ______________

Zip Code: ________ Email: ____________________ Phone Number: ______________

SSN*: ______________________________ Gender: ☐ Male ☐ Female

PROXY INFORMATION – all fields are required

Name: ______________________________ Date of Birth: ______________

Street Address: ______________________________ City/State: ______________

Zip Code: ______________________________ Phone Number: ______________

Email: ____________________ Phone Number: ______________

SSN*: ______________________________ Gender: ☐ Male ☐ Female

*Required for authentication purposes

MYCHART PROXY ACCESS TERMINATION.

By signing this MyChart Adult Proxy Access Termination form, I am requesting that Cape Fear Valley Health System revoke or cancel my above-named proxy's access to my MyChart records. I also acknowledge and understand that my revocation or cancellation request will not affect any disclosures made to my designated proxy until this form is processed and my designated proxy's access is ended.

Patient Signature:______________________________ Date:__________ Time:__________

Print Name:______________________________