MyChart PROXY ACCESS AUTHORIZATION FORM
FOR RELEASE OF INFORMATION

(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)

I am designating (INSERT NAME OF PROXY) _____as my proxy to receive access to my health information that is available in my MyChart records. I understand that the health information in my MyChart records is selected, limited information obtained from my electronic medical record and does not reflect the complete contents of my electronic medical record. I also understand that the health information in my MyChart records may include information from all CFVHS facilities, including but not limited to sensitive health information such as mental health, HIV/AIDS, genetic information, sexual assault, tuberculosis, and venereal disease. I authorize **Cape Fear Valley Health System** to provide proxy access to all of my health information in my MyChart records, including my sensitive health information, to my designated proxy.

I understand that once information has been disclosed, it potentially may be re-disclosed by my designated proxy and the information, once disclosed, is not covered by federal privacy protections.

Participation in MyChart is voluntary. I understand that **Cape Fear Valley Health System** does not condition any of my health care treatment, payment or other services on whether I provide this authorization.

I may revoke this authorization at any time in writing by completing the "Proxy Access Termination Form" and providing it to **Cape Fear Valley Health System**. I understand that if I revoke this authorization, my designated proxy's access to my MyChart records will end. I also understand that my revocation will not affect any disclosures that were made prior to processing the revocation request.

Patient Signature:_____ Date:_____ Time:_____

Print Name:_____