Primary Care Partners
Affiliated with
Atlantic Health System

Patient Information:

Patient Name:		**Patient's Date of Birth:**	

Do you currently hold a MyChart account for your personal medical use? ____ Yes _____No

Proxy Information:

Proxy Name:			
Telephone #:		E-mail:	
Address:	Street		
	City, State, Zip		
	Apt #		

____ ID Verification Obtained (*specify type:*_____)

Proxy Relationship to the Patient:

_____ Spouse ____Adult Child ____ Family Member (specify:_____) ____ Other: _____

Proxy Role Options:

- ☐ Healthcare Proxy (access to ALL available functions of portal: Demographics, Financials, Clinical, Appointments & Messaging)
- ☐ Non-Clincial Proxy (access to: Demographics, Financials, Appointments & Messaging)
- ☐ Guarantor (access to Financials only)

Expiration Date/Right of Revocation of Authorization:

This authorization will remain in effect unless revoked or terminated by the patient in writing to the Care Centers Privacy Officer and/or other authorized representative.

By signing below, I confirm as the PATIENT (for allowing access) and the PROXY (for accepting the duties and responsibilities of being granted access to the Patients medical information) to all the following REPRESENTATIONS AND WARRANTYS:

- I will not share my confidential log-in credentials with anyone else for use within the Patient Portal;
- I understand that MyChart is not to be used in emergency situations. If there is a medical emergency or an urgent medical question, I will call 911 or contact a Primary Care Partners Provider directly;
- As the Proxy, I have read and understand the requirements for accessing the above named Patient's MyChart account information and agree to abide by the according terms and conditions. My signature represents that all of the information provided about me is correct;
- I understand that this authorization pertains to records that we created or existing on or before the date this authorization was signed, as well as records that are created after the date this authorization is signed;
- I may refuse to sign this authorization and understand that my refusal to sign will not affect my ability to obtain treatment. If I refuse to sign this authorization, access to my account will not be granted to the proxy;
- Neither Primary Care Partners Affiliates or its management company, AHS Investment Corporation, are liable for any unauthorized access to your health information that may result from you and your Proxy not protecting your access credentials;

_____ _____

Signature of **Patient** (or Legal Guardian, if patient minor or incapacitated) Date

_____ _____

Signature of **Proxy** Date