Trinity Health Of New England | Medical Group

Guardian for Adult Proxy Form

Access to MyChart Record as a Health Care Agent or Guardian

This form may be used by the personal representative of an incapacitated adult or emancipated minor, with legal authority to make health care decisions on behalf of the incapacitated adult patient or emancipated minor patient. Please note that Trinity Health Of New England Medical Group ("Trinity Health Of NE"), in its sole discretion and in accordance with applicable law, may refuse a personal representative's request to access a patient's health information if Trinity Health Of NE determines it would not be in the best interests of the patient.

Trinity Health Of NE is pleased to offer you information, including access to certain health information of a patient for whom you are the legal representative, via a Web-based version of our computer systems called MyChart (the "Site").

Please note that not all of a patient's Trinity Health Of NE health information will be accessible through the Site. Please refer to Trinity Health Of NE's Notice of Privacy Practices for a description of how to obtain a copy of a patient's Trinity Health Of NE medical record in your role as the personal representative of the patient.

To request access to the Site as a personal representative of a patient, as described above, please complete this form. **Verification of identity and legal documentation must be supplied.**

Please bring this completed form and proper identification to one of the Trinity Health Of New England Medical Group locations.

Your Information (All sections required – please print clearly.)

This section should be completed by the individual requesting access to the Site on behalf of another individual.

Name (*last, first, middle initial*)_____Date of Birth _____

Social Security #:_____Email: _____

Street Address:_____City:_____State:_____Zip: _____

Phone Number: _____

☐ Verified ID Location:_____Employee: _____

Please indicate basis of legal authority to act on behalf of patient for health care (copy of legal documentation must be supplied):

☐ Health Care Agent (pursuant to a Health Care Proxy under Massachusetts law)

☐ Legal Guardian (with authority for health care decision-making)

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Patient's Information (All sections required – please print clearly.)

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

Name (*last, first, middle initial*)_____Date of Birth _____

Social Security #:_____Email: _____

Street Address:_____City:_____State:_____Zip: _____

Phone Number: _____ PCP: _____

Agreement and Acknowledgement

- I understand that the Site is intended as a secure online source of confidential medical information. 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 it may have been compromised in any way.
- I understand that the Site contains selected, limited medical information from the patient's medical record and that the Site does not reflect the complete contents of a patient's Trinity Health Of NE medical record. I also understand that a copy of the patient's medical record may be requested from Trinity Health Of NE's Health Information Management Department.
- I understand that my activities within the Site may be tracked by computer audit and that entries I make may become part of the patient's medical record.
- I understand that access to the Site is provided by Trinity Health Of NE as a convenience to its patients and their legal representatives and that Trinity Health Of NE has the right to deactivate my access to the Site at any time for any reason. I understand that use of the Site is voluntary and I am not required to use the Site.
- I acknowledge receipt of, and agree to comply with, all Terms and Conditions applicable to the Site, as attached hereto,
- By signing below, I acknowledge that I have read and understand the contents of this Proxy Form and the Terms and Conditions and I agree to all terms.

I certify that I am the legally authorized representative of the above-named patient, with legal authority to make health care decisions on behalf of the above named patient, and all information I have provided above is correct.

_____ _____

Date Signature of Legal Representative

_____ _____

Date Witness Signature