



Patient Name

DOB

MRN

Physician

CSN

Authorization TO GIVE MY "ADULT CAREGIVER PROXY ACCESS" TO MYCHART

Since I am an adult (18 years of age and older) patient at Corewell Health, I am able to access my medical records through the MyChart site or application. To begin, I should go to <https://mychart.corewellhealth.org> and choose "New User Sign Up" option to create an account. I will set up a personal username and password for a secure access.

As a patient, I may have special needs, complex health conditions and/or receive support from adult foster care/assisted living/other similar facilities. I am able to give permission for (authorize) my caregivers to have access to MyChart to help care for me. This access allows caregivers to do things like view my medical information, request prescription refills, and schedule appointments.

TO PROTECT MY PRIVACY AND SECURITY:

- I or my legal guardian must authorize "Adult Caregiver Proxy Access".
- I may authorize two (2) caregivers may be granted "Adult Caregiver Proxy Access".
- My selected caregivers may not share the Corewell Health MyChart login information assigned to them for my care.
- My caregiver's access will automatically expire and must be renewed every six (6) months.

"ADULT CAREGIVER PROXY ACCESS" INCLUDES THE ABILITY TO:

- View, schedule, reschedule and cancel upcoming appointments.
- View past appointments and "after visit summaries".
- View and renew medicines.
- Send, receive and view messages to providers in the MyChart "Message Center".
- View test results and result comments.
- View allergies and immunizations.

PATIENT AND LEGAL GUARDIAN/HEALTH CARE ADVOCATE INFORMATION:

PATIENT: Full name _____
Date of birth ____/____/____ Phone (____) _____
Current address _____
City _____ State ____ Zip code _____

Foster home/Facility _____
Address _____
City _____ State ____ Zip code _____

LEGAL GUARDIAN/HEALTH CARE ADVOCATE:

Date of birth ____/____/____ Phone (____) _____
Mailing address _____
City _____ State ____ Zip code _____

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

OVER →

DO NOT MARK BELOW THIS LINE

BARCODE ZONE

DO NOT MARK BELOW THIS LINE



CAREGIVER(S) INFORMATION:

CAREGIVER 1: Full name _____

Date of birth ____/____/____ Phone (____) _____

Current address _____

City _____ State ____ Zip code _____

Email _____

Desired or existing MyChart username* _____

***Note:** The “Adult Caregiver Proxy Access” cannot be the same as the caregiver’s personal MyChart username.

CAREGIVER 2: Full name _____

Date of birth ____/____/____ Phone (____) _____

Current address _____

City _____ State ____ Zip code _____

Email _____

Desired or existing MyChart username* _____

***Note:** The “Adult Caregiver Proxy Access” cannot be the same as the caregiver’s personal MyChart username.

I UNDERSTAND:

- “Adult Caregiver Proxy Access” gives the caregiver access to my medical record through Corewell Health MyChart. A medical record may include health information about my immunizations, test results, hospital/outpatient notes, messages, medicines and appointment information, to assist with patient care.
- Corewell Health has privacy standards and responsibilities the caregiver must follow. If not followed, my caregiver has the potential to share information in my medical record.
- I should call MyChart Customer Support at 877.308.5083 if:
 - I want to cancel “Adult Caregiver Proxy Access” of a caregiver.
 - The person who is my Legal Guardian/Patient Advocate has changed.
- After submitting my authorization, Corewell Health will confirm the identity of all noted on this form.

☒ **I authorize “Adult Caregiver Proxy Access” be given this/these caregiver(s) (listed above).**

To fully complete this authorization, I must:

- Include a copy of the caregiver’s legal identification (ID) or driver’s license when submitting this form.
- Include a copy of my own (patient or Legal Guardian/Patient Advocate) legal ID or driver’s license when submitting this form.
- If the Legal Guardian/Patient Advocate: Include a copy of the document giving you guardianship or Power of Attorney. Corewell Health will confirm your legal connection to the patient.
- Time/date/sign below.
- Send this completed authorization form and copies of the documents (noted above) to:
Fax: 616.391.8966 **OR** Email: chhimstatscans@corewellhealth.org.

TIME _____ DATE _____

Patient/Legal Guardian/Patient Advocate signature _____

NOTE:

- Corewell Health will complete your request in five to seven business days.
- For more information on how Corewell Health may use and/or disclose health information, refer to Corewell Health Notice of Privacy Practices.