Patient Printed Name:_____ Patient Date of Birth: _____

Patient Street Address: _____

City:_____ State:_____ ZIP:_____

Patient Social Security Number (**last four digits only**): _____

I authorize Parkview Health System, Inc., its affiliated healthcare providers, and their business units, including Parkview Physicians Group, (all referred to as "Parkview") to share information about me, or the patient for whom I am the legal representative, as described below.

1. The following person may receive information from my medical records by having access to my records through the MyChart web portal. I also authorize the following person to request a MyChart activation code and activate a MyChart account on my behalf, if I do not already have a MyChart account.

   Name: _____ Date of Birth: _____

   Street Address:_____

   City:_____ State:_____ ZIP: _____

   Relationship to Patient:_____ Phone #:_____

2. The purpose is to provide access to those portions of my Parkview electronic medical record available through MyChart to persons involved with me and my healthcare.
3. This authorization and the access to my medical records through MyChart shall remain in effect until I revoke or cancel it.
4. This authorization is voluntary. I know that I may revoke or cancel it at any time, except to the extent that action has already been taken in reliance upon it. To revoke or cancel it, I will send a signed and dated letter to Parkview Health, Health Information Management, Attention: MyChart, 2200 Randallia Drive, Fort Wayne, IN 46805.
5. If I do not sign this form or if I later revoke or cancel my authorization, it will not affect any treatment, payment, or enrollment or eligibility for benefits which I am eligible to receive from Parkview.
6. I confirm that I have had the opportunity to read and consider the contents of this authorization, and I agree to be bound by them. I release Parkview from any legal responsibility or liability for providing MyChart access to the person listed above. I understand that this person might not keep my information confidential and that it might not be protect by federal and state privacy laws any longer.

Signed proxy access forms should be faxed to: 260-373-3781, Attention: MyChart, or mailed to:
Parkview Health, Health Information Management, Attention: MyChart, 2200 Randallia Drive, Fort Wayne, IN 46805

Patient/Parent/Guardian/Legal Representative Signature: _____ Date:_____

Relationship to Patient: _____

Parent/Guardian Authorization for Minor to Access Own MyChart Account

I, (name)_____, the parent/guardian of (child's name) _____, who is between the ages of 14 and 17 years old, authorize him/her to access his/her own MyChart account.

Parent/Guardian Signature:_____ Date:_____

PARKVIEW PHYSICIANS GROUP

MYCHART PROXY OR MINOR ACCESS AUTHORIZATION

Patient Name: _____

Patient ID Number: _____

DOB: _____