

**PATIENT REQUEST FOR MyChart PROXY ACCESS**  
(For patient to give another person or parent/legal guardian access to the patient's MyChart)

If you are 18 years of age or older and would like another adult to access your medical information contained in MyChart, then you, as the patient, should complete this form.

If you are 13-17 years old, you may only request proxy access for a parent or legal guardian, and you should complete this form.

If you are a parent of an unemancipated minor patient under the age of 13 or legal guardian of a patient under the age of 13 and would like to access the patient's medical information contained in MyChart, then you should complete this form.

Patient's Full Name: \_\_\_\_\_ Date of Request: \_\_\_\_\_

Patient's Medical Record Number: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

Patient's Address: Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient's Telephone Number: Home: (        ) \_\_\_\_\_ Work: (        ) \_\_\_\_\_ Cell: (        ) \_\_\_\_\_

Name of Proxy: \_\_\_\_\_

Proxy's Date of Birth: \_\_\_\_\_

Proxy's Address: Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Proxy's Telephone Number: Home: (        ) \_\_\_\_\_ Work: (        ) \_\_\_\_\_ Cell: (        ) \_\_\_\_\_

Proxy's E-Mail Address: \_\_\_\_\_

Proxy's Relationship to Patient:             Parent     Legal Guardian     Other Adult

Has the proxy ever been a patient at the OSU Wexner Medical Center or affiliated hospital?  Yes             No             Don't Know

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**Please Read Carefully**

I understand that my medical information is in MyChart. This may include personal and private information and results of tests and treatments I have had.

I know that my proxy could share information that is in MyChart with others. I know there may not be laws that protect my privacy in this case.





**THE OHIO STATE UNIVERSITY**

WEXNER MEDICAL CENTER

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Witness (Optional)

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Date Signed

For Clinic Office Staff Only

Name of Clinic: \_\_\_\_\_

Office Associate's Name Confirming Identity of Person Completing Form: \_\_\_\_\_

Office Associate's Contact Number: \_\_\_\_\_

Date Scanned: \_\_\_\_\_