MyChart

Lexington Health

Proxy for Adult Application Requiring Legal Documentation of Permanent Legal Guardianship or Durable Power of Attorney for Healthcare

This form must be completed by the individual requesting proxy access to the MyChart record of an adult patient age 16 or older who cannot make his/her health care decisions. The requester must have Durable Power of Attorney for Health Care or be the permanent legal guardian for the patient of Lexington Health and/or its affiliated clinics. The requester must present photo identification and provide copies of the appropriate legal documents.

Adult Patient Information

NAME_____ _____ _____
LAST FIRST MIDDLE INITIAL

Date of Birth (MM/DD/YY): _____ Last Five Digits of Patient's SSN#: _____

Street Address: _____

City, State, ZIP: _____

Phone Number: (_____) _____

PROXY (Legal Guardian or DPOA) Information

NAME_____ _____ _____
LAST FIRST MIDDLE INITIAL

Date of Birth (MM/DD/YY): _____ Last Five Digits of Proxy's SSN#: _____

Street Address: _____

City, State, ZIP: _____

Phone Number: (_____) _____

Email: _____

My relationship to the patient is as follows (Check One)

☐ **Permanent Legal Guardian of the Patient**
Proxy must attach a copy of the court order appointing guardian and letters of guardianship verifying the proxy's status as permanent legal guardian of the patient.

☐ **Activated Durable Power of Attorney for Healthcare (DPOA)**
Proxy must attach a copy of the valid DPOA for Health Care and statutorily required certifications verifying the patient lacks decisional capacity.

By signing below, I acknowledge and agree that:

- I will be using my own MyChart account to access the patient's MyChart account.
- I will comply with the terms and conditions on the MyChart website.
- I have provided the proper documentation authorizing me as a legal representative for this patient, thereby allowing me access to portions of his or her medical record through MyChart.
- When my legal authority to act on behalf of the patient has been inactivated, revoked, terminated or expired, I will immediately notify Lexington Medical Center or the patient's primary physician clinic in writing of the revocation, termination or expiration.
- Even if my legal authority to act on behalf of the patient has not been inactivated, revoked, terminated or expired, my access to the patient's MyChart Account will expire one year from the date the proxy relationship is created in the system. I will then need to complete this form again to obtain access for an additional year.

_____ _____

PROXY SIGNATURE (REQUIRED) DATE & TIME (REQUIRED)

_____

RELATIONSHIP TO PATIENT (REQUIRED

FOR STAFF USE ONLY

1. I have attached copies of all required legal documents.
2. I have given a photocopy of the signed MyChart Authorization to the patient or the patient's representative.
3. I have viewed the proxy's photo ID.

_____ _____

NAME OF LEXINGTON MEDICAL CENTER STAFF WHO VALIDATED PROXY ACCESS (PLEASE PRINT) DATE VALIDATED