

| Name: _ | (Last Name) | (First Name) | (Middle Initial) |
|------------|-------------|--------------|------------------|
| DOB: _ | | MRN#: | |
| HAR#/DAR#: | | CSN#: | |

New Hanover Regional Medical Center

NHNHRMC AND AFFILIATED COVERED ENTITIES MyChart ADULT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

This authorization will permit NHNHRMC and its affiliated covered entities to release your medical information to your designated adult proxy. Please read it carefully.

This form should be completed by the patient who is authorizing another adult to access medical information in his or her MyChart record. It must accompany the Adult Proxy Request, which provides the name and information of the individual who the patient is authorizing to access their MyChart record as a proxy.

| the patient to dution zing to decode their my chart record de t | a proxy. |
|--|--|
| Patient name (last, first, middle initial): | |
| Social Security #: (last five digits only): XXX-X | Date of Birth: |
| information on MyChart is obtained from my electronic medic the affiliated covered entities. I authorize release of any infor | d. This person is my designated MyChart proxy. I authorize art record to my MyChart proxy. I understand that the medical |
| I authorize release of this information only through my MyCh record to my designated proxy by other methods or in other | art record. This form does not authorize release of my medical forms. |
| I understand that once health information has been disclosed the disclosed information may no longer be covered by feder | d, the recipient may potentially re-disclose that information and ral privacy protections. |
| Participation in MyChart and designating a MyChart proxy is designate a MyChart proxy and I am not required to provide affiliated covered entities does not condition any of my health this authorization. However, I also understand that if I do not entities are not permitted to provide access to my MyChart re | this authorization. I also understand that NHNHRMC and its n care treatment, payment or other services on whether I provide provide authorization, NHNHRMC and its affiliated covered |
| 28402. I understand that if I revoke this authorization, my de | : Health Information Management POB 2400 Wilmington, NC signated proxy's access to my MyChart record will be ended. I sures that were made prior to processing the revocation request. |
| Signature:(Patient or Authorized Representative) | Date: |
| Printed name: | |
| If person other than the patient signs, indicate authority to signs, and indicate authority to signs, and a signs, and | gn for patient (e.g., guardian) and attach documentation. |

THIS FORM IS PART OF THE PERMANENT MEDICAL RECORD



| Name: | (Last Name) | (First Name) | (Middle Initial) |
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New Hanover Regional Medical Center

NHNHRMC AND AFFILIATED COVERED ENTITIES MyChart ADULT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Access to Another Adult's MyChart Record

To request access to the MyChart record of an adult whose medical care you help manage, please complete this request. The patient must sign this form and provide authorization for release of medical information on the MyChart Adult Proxy Authorization for Release of Medical Information (NS-2140). Please note that the patient's chart will be accessed through your (the proxy's) MyChart record. Completing this request will establish a MyChart record for you and/or for the patient.

| Return all forms to: NHNHRMC Attn: HIM Departme or Fax (910) 667-5631 | nt PO Box 2400 | Wilmington, NC | 28402 | |
|---|----------------|----------------|---------|--|
| Requestor's Information - This should be completed by the individual requesting access to another adult's MyChart record. (Complete all sections - please print clearly) | | | | |
| COPY OF PHOTO ID REQUIRED: (Drivers License, State issued ID, Military ID, Passport) | | | | |
| Name (last, first, middle initial): | | | Gender: | |
| Social Security #: (last five digits only): XXX-X | | | | |
| Street Address: | | | | |
| City: | | | Zip: | |
| Phone Number: E | mail: | | | |
| Patient's Information – Complete this section with information about the patient whose MyChart record you are requesting to access. (Complete all sections – please print clearly) COPY OF PHOTO ID REQUIRED: (Drivers License, State issued ID, Military ID, Passport) Name (last, first, middle initial): | | | | |
| Social Security #: (last five digits only): XXX-X | | | | |
| Street Address: | | | | |
| | | | 7: | |
| City: | | State: | ZIP: | |
| City: Ei | nail: | State: | | |

- I understand that MyChart contains selected, limited medical information from a patient's medical record and that MyChart does not reflect the complete contents of the medical record. I also understand that a copy of a patient's medical record may be requested from NHNHRMC Health Information Management Department.
- I understand that my activities within MyChart may be tracked by computer audit and that entries I make may become part of the medical record.
- I understand that access to MyChart is provided by NHNHRMC as a convenience to its patients and that NHNHRMC and affiliated covered entities have the right to deactivate access to MyChart and that the patient may terminate my access to that patient's health information at any time for any reason. I understand that use of MyChart is voluntary and I am not required to use MyChart or to authorize a MyChart proxy.
- By signing below, I acknowledge that I have read and understand this MyChart Proxy Request and I agree to its terms. I

| also understand that use of MyChart may be subject to other | Terms and Conditions, which ma | y change from time to time. |
|---|--------------------------------|-----------------------------|
| Proxy Signature (Required) | Relationship to Patient | Date |
| I acknowledge that I have read and understand the MyChart Adult the person named above as my MyChart Proxy, thereby allowing | | |
| Signature of Patient or authorized representative (Required) | Relationship to Patient | Date |

THIS FORM IS PART OF THE PERMANENT MEDICAL RECORD

