

Family Access Form MyChart Proxy Adult

Patient Name: _____	DOB: _____	MRN: _____
Proxy Name: _____	DOB: _____	MRN: _____
Proxy Address: _____		Phone #: _____
Does Proxy Have a My K-Chart account ____ Yes ____ No (if no fill out email legibly)		
Proxy Email _____		
Relation to Patient: _____		

I agree to give family (proxy) access to My K-Chart to the proxy listed above. I understand that this gives access to my medical information currently available and that may become available as a result of future medical care. I understand that I may revoke access at any time.

_____	_____
Patient Signature	Date
_____	_____
Witness Signature	Date

This form may be returned to Health Information Management via fax or email. Please be sure to fill in all requested fields – missing information may result in a delay of access to the requested account.

Fax: (509) 786-2349

Email: medicalrecords@pphdwa.org

