Patient Information

Full Name _____ Date of Birth _____

Maiden or Other Names Used _____ SSN: xxx-xx-_____ (last 4 digits)

Address _____
City State Zip

Day Phone _____ Cell Phone _____

Parent/Guardian/Legal Personal Representative

Full Name _____ Date of Birth _____

Email _____ SSN: xxx-xx-_____ (last 4 digits)

Relationship to Patient _____ I have my own personal Intermountain Health MyChart account: ☐ Yes ☐ No

Address _____
City State Zip

Day Phone _____ Cell Phone _____

Additional Parent/Guardian/Legal Personal Representative

Full Name _____ Date of Birth _____

Email _____ SSN: xxx-xx-_____ (last 4 digits)

Relationship to Patient _____ I have my own personal Intermountain Health MyChart account: ☐ Yes ☐ No

Address _____
City State Zip

Day Phone _____ Cell Phone _____

I Understand That

- Legal documentation (e.g. Medical Power of Attorney, Guardianship, Legal Personal Representative) is required.
- If access to the patient's Intermountain Health MyChart is granted, access will remain in effect until **revoked t**hrough MyChart or in writing at any time.
- If access to Intermountain Health MyChart is revoked, the information previously viewed by the above named person(s) would not be considered a breach of confidentiality.
- Information accessed may be subject to **redisclosure** by the Parents/Guardians/Legal Representatives and is no longer protected by the HIPAA Privacy rule.
- The patient's Intermountain Health MyChart may include a diagnosis or reference to the following condition(s): behavioral health services/psychiatric care; sickle cell anemia; genetic testing; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); or drug and/or alcohol abuse.
- Intermountain Health reserves the right to revoke access to the Intermountain Health MyChart at any time for any reason.

A signature is required to validate this request. By signing this form, the signer is requesting that the person(s) named above be granted access to electronically view the patient's medical record via the Intermountain Health MyChart.

_____

Signature and PRINTED Name of Parent/Guardian/Legal Personal Representative Date Time

Submit Completed Form To

Return Completed Form to: The Intermountain Health Clinic where the patient last received services or the Hospital's Health Information Management Department.

Direct Questions to: Intermountain Health MyChart Patient Support Line toll free at 855-274-2517.

For Office Use Only

Date Request Received: _____ By: _____

Date Request Completed: _____ By: _____

Identification/Driver's License Verified: _____ (initials)

Requestor: ☐ Access granted ☐ Access denied

Additional Requestor: ☐ Access granted ☐ Access denied

Intermountain Health

ON107

Request for MyChart PROXY Access (for use by Parents/Guardians/Legal Personal Representatives)

A-MR-0611-0823

Peaks Region

Place patient label here.
Scanning does NOT work if label is outside this guide.