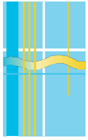

Covenant Health, Inc.
MyChart Proxy Access Authorization Form

Name: ____
Patient Email: ____
Patient Date of Birth: ____
Patient MRN: ____
Name of Proxy: ____
Proxy Email: ____
Proxy Address: ____
Proxy DOB: ____

By signing this MyChart Proxy Access Authorization Form (this "Authorization"), I understand that I am giving permission to the Covenant Health, Inc., and its controlled affiliates that operate one or more hospitals or physician to disclose confidential health information contained about me through MyChart to the person whose name is designated above (my "Proxy").

I understand that MyChart is a web-based service through which some of the information contained in my Covenant Health electronic medical record ("EMR") may be accessed, and that MyChart sometimes shows a summary or description and not the actual entries in my EMR. I understand that by signing this Authorization, my Proxy will be given electronic access through MyChart to all confidential health information about me that is available through MyChart, including confidential health information about me that under most circumstances my Proxy would not be able to access without my permission.

I understand that I am not required to name a Proxy or sign this Authorization. I further understand that Covenant Health may not condition treatment or payment on my willingness to sign this Authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this Authorization.

I understand that this Authorization is valid unless and until I revoke it. I understand that I have the right to revoke this Authorization at any time, but that my revocation will not be effective until delivered in writing, signed and dated to Covenant Health at the following address:

Covenant Health MyChart Support
St. Joseph Health Information Management Department
360 Broadway
Bangor, ME 04401

If I choose to revoke this Authorization, I understand that my revocation will not be effective as to any MyChart information already disclosed to my Proxy pursuant to this Authorization.

I understand that MyChart access is a privilege, not a right, and that my Proxy must agree to comply with the MyChart Terms and Conditions of Patient Use (the "Terms and Conditions"). Covenant Health will provide my Proxy a special activation code and instructions for accessing confidential health information about me in MyChart. The first time my Proxy uses the special activation code, my Proxy must review and accept the Terms and Conditions and the Proxy

Disclaimer. If my Proxy does not accept and at all times comply with the Terms and Conditions or does not accept the Proxy Disclaimer each time my Proxy accesses MyChart, I understand that Covenant Health may deny my Proxy access or revoke my Proxy's to access to confidential health information about me in MyChart. I also understand that Covenant Health may deny my Proxy access or revoke my Proxy's access for any reason and at any time in Covenant Health's sole discretion.

I understand that my Proxy must sign the Acknowledgement set forth below if my Proxy is in the office with me at the time I complete this request. If my Proxy is not in the office with me, I understand that my Proxy will be mailed a "Proxy Identification Verification for Access to Covenant Health MyChart" form at the address I have designated above, and that my Proxy must complete and return the form to Covenant Health before Covenant Health will take any additional steps to give my Proxy access information about me in MyChart.

A copy of this Authorization and a notation concerning my Proxy shall be included in my original health records. I understand that I am entitled to a copy of this authorization form. I understand that confidential health information about me disclosed in MyChart to my Proxy pursuant to this Authorization might be redisclosed by my Proxy and may, as a result of such disclosure, no longer be protected to the same extent as such confidential health information was protected by law while solely in the possession of Covenant Health.

____

Signature of Patient of Legal Guardian   Date (MM/DD/YYYY)

____

Printed Name of Patient or Legal Guardian   Relationship (if not self)

ACKNOWLEDGEMENT TO BE COMPLETED BY PROXY IF IN OFFICE:
I acknowledge and agree that the above information, including my name, e-mail address, date of birth, Social Security Number, and mailing address are true and correct. I further agree to comply with the Terms and Conditions and Proxy Disclaimer.

____

Proxy Signature   Date (MM/DD/YYYY)

____

Printed Name of Proxy

Identification Document:

__ Driver's License/Government Issued ID

__ Passport

__ Picture ID & Social Security Card

Identification Document Number____

Expiration Date ____