Neighborhood Outreach Access to Health

MyChart Adult Proxy Access

For patients 18 years or older, parents, legal guardians, or caregivers can request proxy access, with the patient's or authorized person's consent, by completing this Adult Proxy Access form. The patient can also complete this form on the NOAH website at **www.noahhelps.org/MyChart**.

What is proxy access?

Proxy access allows a parent, legal guardian or caregiver to link a patient's MyChart account to their own MyChart account. Linking the patient's MyChart account to their own will allow a parent, legal guardian or caregiver (the proxy) to view and manage the personal health information of the patient.

If the proxy or the patient listed below doesn't currently have a MyChart account, by submitting this form, a MyChart account will automatically be created.

Proxy Information *(All sections required – please print clearly.)*

Complete this section with information about the individual having proxy access to the adult patient MyChart record.

Name *(last, first, middle initial)* _____ Date of Birth: ___"/ _ __"/ ___

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____"Email: _____

Patient Information *(All sections required – please print clearly.)*

Complete this section with information about the patient.

Name *(last, first, middle initial)* _____ Date of Birth: ___"/ _ __"/ ___

Gender: ☐ Male ☐ Female Email: _____

Street Address: _____ City: _____ State: _____ Zip: _____

By signing below, I acknowledge that I have read and understand this Adult Proxy Access form and agree to the MyChart terms and conditions found at **mychart.ochin.org/noahhelps.**

▶_____ /_____ / _____

Proxy Signature *(Required)* **Relationship to Patient** **Date**

By signing below, I acknowledge that I have read and understand this Adult Proxy Access form, agree to its terms, and choose to designate the person named above as my MyChart Proxy, which will allow them access to my MyChart medical record.

▶_____ /_____ / _____

Signature of Patient or Authorized Person *(Required)* **Relationship to Patient** **Date**

Submit Completed Forms to:

NOAH - Health Information Management

Mail: 7500 N. Dreamy Draw Dr., Ste 145, Phoenix, AZ 85020

Email: him@noahhelps.org

Fax: 480-882-4594

Forms can also be dropped off at any NOAH Health Center Front Desk.