



Affix Patient Label

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Allowing Another Person to Look at Bronson MyChart Record (Ages 12 and up)

**Proxy Information** (Please print clearly and fill out all parts)

Name (*last, first, middle initial*): \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Email: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Bronson clinic where I get most of my care: \_\_\_\_\_

**My Information** (Please print clearly and fill out all parts)

Name (*last, first, middle initial*): \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Email: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Bronson clinic where I get most of my care: \_\_\_\_\_

I want \_\_\_\_\_ (name of person who can look at my information) to be able to see my health information in my Bronson MyChart Record. This person is called a “proxy.”

I understand that:

- MyChart information comes from the computerized medical record at Bronson Hospital and Bronson clinics.
- The information may come from all the places that are listed in Bronson’s Notice of Privacy Practices.
- Having a MyChart proxy does not mean that my proxy can look at all of my Bronson medical records. My proxy can only look at the information in MyChart.
- I don’t need to have a proxy. I have decided, on my own, that I want the proxy to be able to look at MyChart.
- I can change my mind and stop the proxy from looking at MyChart. There are two ways to do this: I can write a note to my doctor’s office saying that I do not want the proxy to look at MyChart. Or I can go to MyChart on a computer and make the change there.
- If I let the proxy look at MyChart, it is no longer private. The proxy can make a copy of my record or can share it with other people.

I want Bronson Healthcare Group to give health information contained in MyChart record to the proxy.

Date: \_\_\_\_\_ Primary Practice: \_\_\_\_\_

Signature of Patient (or authorized person): \_\_\_\_\_

Printed Name: \_\_\_\_\_

If person other than the patient signs, indicate relationship to patient (e.g., guardian) and attach documentation: