☐ **Proxy Access Granted** ☐ **Needs Proxy Access**

For HIM: ☐ **Proxy Access Granted**

Signed proxy access forms should be faxed to 260-665-7882, Attention: HIM, MyChart or mailed to:
Cameron Memorial Community Hospital, Attn: Health Information Management, 416 E. Maumee Street, Angola, IN, 46703

Please complete the following information for the individual whose medical information will be shared.

Patient Printed Name _____ Patient Date of Birth _____

Patient Street Address _____

City _____ State _____ Zip Code _____

Last four digits of patient's social security number _____

I authorize Cameron Memorial Community Hospital, and healthcare providers, and their business units (all referred to as "Cameron") to share information about me, or the patient for whom I am the legal representative, as described below.

1. The following person may receive information from my medical records by having access to my records through the MyChart web portal. I also authorize the following person to request a MyChart activation code and activate a MyChart account on my behalf, if I do not already have a MyChart account.

   Name _____ Date of Birth _____

   Street Address _____

   City _____ State _____ Zip Code _____

   Relationship to Patient _____ Phone number _____

2. The purpose is to provide access to those portions of my Cameron electronic medical record available through MyChart to persons involved with me and my healthcare.

3. This authorization and the access to my medical records through MyChart shall remain in effect until I revoke or cancel it.

4. This authorization is voluntary. I know that I may revoke or cancel it at any time, except to the extent that action has already been taken in reliance upon it. To revoke or cancel it, I will send a signed and dated letter to:
   Cameron Memorial Community Hospital, Attn: Health Information Management, 416 E. Maumee Street, Angola, IN, 46703

5. If I do not sign this form or if I later revoke or cancel my authorization, it will not affect any treatment, payment or enrollment or eligibility for benefits which I am eligible to receive from Cameron.

6. I confirm that I have had the opportunity to read and consider the contents of this authorization, and I agree to be bound by them. I release Cameron from any legal responsibility or liability for providing MyChart access to the person listed above. I understand that this person might not keep my information confidential and that it might not be protected by federal and state privacy laws any longer.

Patient/Parent/Guardian/Legal Representative Signature _____

Relationship to Patient _____ Date _____ Time _____

If guardian or legal representative sign the form, please provide documentation.

Parent/Guardian Authorization for Minor Access to Own MyChart Account

I, _____, the parent/guardian of (child's name) _____ who is between the ages of 14 and 17 years old, authorize him/her to access his/her own MyChart account.

Parent/Guardian Signature _____ Date _____ Time _____

All entries must be dated and timed

Witness Name _____

Witness Signature _____

Date _____ Time _____

CAMERON
MEMORIAL COMMUNITY HOSPITAL
Your independent community health partner.

MyChart Proxy or Minor Access Authorization

Patient Name _____

Patient ID Number _____

DOB _____