Trinity Health
Of New England

Patient Label

## MyCare Proxy Access Authorization

To request access to the MyCare record of a patient whose medical care you help manage, please complete this form and return it to Trinity Health Of New England MyCare Support Team by scanning it and emailing it to: mycaresupport@trinityhealthofne.org. *Please note that the patient must also sign this form.*

| **PATIENT INFORMATION** (please complete all requested info) | |
|---|---|
| **Patient Name:** | **DOB:** |
| **Street Address:** | **Email** (if applicable)**:** |
| **City, State, Zip:** | **Phone:** |
| **Last 4 digits of SSN:** | |

| **PROXY INFORMATION** (please complete all requested info) | |
|---|---|
| **Proxy Name:** | **DOB:** |
| **Street Address:** | **Email** (required)**:** |
| **City, State, Zip:** | **Phone:** |
| **Last 4 digits of SSN:** | **Relationship to Patient:** |

### Proxy Agreement to MyCare Terms and Conditions

As a proxy designated by the patient named above, I understand and agree to the following:

- MyCare contains selected, limited medical information from the patient's medical record and does not reflect the complete contents of the medical record. A paper copy of the patient's medical record may be requested from the patient's health care provider.
- My activities within MyCare are tracked by computer audit, and entries I make can become part of the above-named patient's medical record.
- I understand that my access to any information about the patient may be revoked by the patient or terminated by Trinity Health Of New England at any time without notice.
- I agree to abide by the Trinity Health Of New England MyCare Terms and Conditions, which are available at: https://mycare.stfranciscare.org/mycare/default.asp?mode=stdfile&option=termsandconditions.

By signing below, I acknowledge that I am providing documentation of my authorization to access the protected health information of the patient described above. I certify that I am legally authorized to access such information about the patient named above, and that the information I have provided is true and correct.

**Proxy Signature:** Date: Time:

### Patient Acknowledgement

I acknowledge that I have read and understand this MyCare Proxy Access Authorization form. I agree to its terms and designate the person named above as my MyCare Proxy, thereby allowing him/her access to my MyCare medical record.

**Patient Signature:** Date: Time: