National Jewish Health Health Information Management | 1400 Jackson Street, L07, Denver, CO 80206 | 303.398.1580 **phone** | 303.398.1211 **fax**

1. PATIENT INFORMATION

Patient Name (Last, First)			DOB __ __ / __ __ / __ __ __ __
Email Address			Social Security Number XXX-XX __ __ __ __(last 4 digits)
Address	City	State	Zip
Day Phone #	Cell #		

2. PARENT/GUARDIAN/LEGAL PERSONAL REPRESENTATIVE

Full Name (Last, First)			DOB __ __ / __ __ / __ __ __ __
Email Address			Social Security Number XXX-XX __ __ __ __(last 4 digits)
Relationship to Patient	I have my own Personal National Jewish Health MyChart account: Yes ☐		No ☐
Address	City	State	Zip
Day Phone #	Cell #		

3. ADDITIONAL PARENT/GUARDIAN/LEGAL PERSONAL REPRESENTATIVE

Full Name (Last, First)			DOB __ __ / __ __ / __ __ __ __
Email Address			Social Security Number XXX-XX __ __ __ __(last 4 digits)
Relationship to Patient	I have my own Personal National Jewish Health MyChart account: Yes ☐		No ☐
Address	City	State	Zip
Day Phone #	Cell #		

4. I UNDERSTAND THAT

- Legal documentation (e.g., Medical Power of Attorney, Guardianship, Legal Personal Representative) is required.
- If access to the patient's National Jewish Health MyChart account is granted, access will remain in effect until revoked through MyChart or in writing at any time.
- If access to a National Jewish Health MyChart account is revoked, the information previously viewed by the above named person(s) would not be considered a breach of confidentiality.
- Information accessed may be subject to redisclosure by the Parents/Guardians/Legal Representatives and is no longer protected by the HIPAA Privacy rule.
- The patient's National Jewish Health MyChart account may include a diagnosis or reference to the following condition(s): behavioral health services/psychiatric care; sickle cell anemia; genetic testing; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); or drug and/or alcohol abuse.
- National Jewish Health reserves the right to revoke access to the National Jewish Health MyChart account at any time for any reason.

A signature is required to validate this request. By signing this form, the signer is requesting that the person(s) named above be granted access to electronically view the patient's medical record via the National Jewish Health MyChart account.

_____ _____ _____

Signature of Parent/Guardian/Legal Personal Representative **Printed Name** Date

5. SUBMIT COMPLETED FORM

Return Completed Form to: Health Information Management Department via postal mail, fax, or in person on the National Jewish Health main campus.

Direct Question to: Health Information Management at **303.398.1580**.

National Jewish Health®

Request for MyChart Proxy Access

HIPAA Patient Request _CC

Medical Record # _____

For Office Use Only

Date Request Received: _____ By: _____

Date Request Completed: _____ By: _____

Identification/Driver's License Verified: _____ (initials)

Requestor: Access granted ☐ Access denied ☐

Requestor: Access granted ☐ Access denied ☐