PATIENT AUTHORIZATION FOR PROXY ACCESS TO MYCHART/

Patient's Name:

____

(Last) (First) (Middle)

MS MRN: ________________ Date of Birth: __________________ Tel.No.:___________________

Month/Day/Year

Address: ____

(Street) (City) (State) (Zip Code)

Please provide Proxy Access to my MyChart account to:

Name: ____

Email Address: ____

By completing this form I authorize The Brooklyn Hospital Center (TBHC) to disclose my medical information to the above named person by providing them with Proxy Access to my MyChart. I understand that proxy access will provide access to information and functionality that I have in My Chart. This will not include access to HIV-related information, mental health treatment information, substance abuse information, and genetic information.

I understand information may be re-disclosed if the above named person is not required by law to protect the privacy of the information.

I understand that if I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (800) 523-2437 / (212) 480-2493 or the New York City Commission on Human Rights at (212) 306-7450.

I understand that TBHC will not condition treatment or payment on whether I sign this authorization. However, if I do not sign, TBHC will not provide the person with access to my MyChart.

I understand that this authorization is valid until I revoke it.

I may revoke this authorization at any time, except to the extent TBHC has already taken action based my authorization, by contacting MyChart at MyChart@tbh.org or 718-250-8333.

Patient Signature: ___________________________________ Date: ___________________________

THIS DOCUMENT MUST BE SCANNED INTO THE PATIENT'S MEDICAL RECORD.

PATIENT MUST BE PROVIDED WITH A COPY OF THIS DOCUMENT