



# My Sanford Chart

## Adult/Teen Proxy Form

### Access to Another Adult/Teen My Sanford Chart Account

To request access to the My Sanford Chart account of an adult or teen (age 12-17) whose medical care you help manage, please complete this form and bring it with you to your next clinic visit or mail it to the nearest address shown below. The patient must sign this form and provide authorization for release of medical information in My Sanford Chart on the "Adult/Teen Proxy Authorization Form." Please note that the patient's information will be accessed through your (the proxy's) My Sanford Chart account. Completing this form will establish a My Sanford Chart account for you and for the patient.

**Return forms to:** Sanford: 900 East 48<sup>th</sup> Street North; Sioux Falls, SD 57104, or  
Sanford: Attention: Release of Information; P.O. Box 2010; Fargo, ND 58122-0007

#### Your (Proxy) Information: (All sections required – please print clearly.)

**This section should be completed by the individual requesting access to another My Sanford Chart account.**

Name (*last, first, middle initial*) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Last 4 Digits of Social Security Number: \_\_\_\_\_ Email: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

#### Patient's Information: (All sections required – please print clearly.)

**Complete this section with info about the patient whose My Sanford Chart account you're requesting to access.**

Name (*last, first, middle initial*) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Last 4 Digits of Social Security Number: \_\_\_\_\_ Email: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

#### My Sanford Chart Terms and Agreement

- I acknowledge and agree that while My Sanford Chart contains a "Message Center" for patients age 18 and older, such messaging shall not be used for medical emergencies. Rather, I will call 911 in the event of a medical emergency.
- I understand that My Sanford Chart is intended as a secure online source of confidential medical information. If I share My Sanford Chart ID and password with another person, that person may be able to view my health information or my child's health information, and health information about anyone who has authorized me as a My Sanford Chart proxy.
- I understand that the information in My Sanford Chart may include billing information associated with my account. I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.
- I understand that My Sanford Chart contains selected, limited medical information from a patient's medical record and that My Sanford Chart does not reflect the complete contents of the medical record. I also understand that a paper copy of a patient's medical record may be requested.
- I understand that my activities within My Sanford Chart may be tracked by computer audit and that entries I make may become part of the patient's medical record.
- I understand that access to My Sanford Chart is provided by Sanford as a convenience to its patients and that Sanford has the right to deactivate access to My Sanford Chart at any time for any reason. I understand that use of My Sanford Chart is voluntary and I am not required to use My Sanford Chart or to authorize a My Sanford Chart proxy.
- By signing below, I acknowledge that I have read and understand this My Sanford Chart Sign-Up Form and I agree to its terms.



\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Your (Proxy) Signature (Required)**

**Relationship to Patient**

**Date**

I acknowledge that I have read and understand this My Sanford Chart Sign-up form. I agree to its terms and choose to designate the person named above as My Sanford Chart Proxy, thereby allowing them access to My Sanford Chart medical record.



\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Signature of Patient (or authorized person) (Required)**

**Relationship to Patient**

**Date**



\_\_\_\_\_ / \_\_\_\_\_

**Witness (in clinic only) or Notary (Required)**

**Date**



**Please remember to complete page 2 of this form.**

# My Sanford Chart

## Adult/Teen Proxy Authorization for Release of Medical Information

**This form is an authorization that will permit Sanford to release your medical information to your designated proxy. Please read it carefully.**

**This form should be completed by the patient who is authorizing another adult to access medical information in his or her My Sanford Chart account. It must accompany the Adult Proxy Form, which provides the name and information of the individual who the patient is authorizing to access their My Sanford Chart account as a proxy. If you do not have an Adult Proxy Form, please contact your clinic, or download one from [www.mysanfordchart.org](http://www.mysanfordchart.org).**

Patient Name (*last, first, middle initial*) \_\_\_\_\_

Last 4 Digits of Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I am requesting that \_\_\_\_\_ (*insert name of proxy*) receive access to my information that is available in My Sanford Chart account. I designate this person as my proxy for My Sanford Chart. I authorize Sanford to release the information contained in My Sanford Chart account to my proxy. I understand that the information in My Sanford Chart may include my medical information as well as billing information associated with my account. I authorize release of any information contained in My Sanford Chart to my proxy.

I authorize the release of this information only through My Sanford Chart. This form does not authorize release of my medical record to my proxy by other methods or in other forms.

I understand that once information has been disclosed to my proxy, it may be re-disclosed and no longer protected.

Participation in My Sanford Chart and designating a proxy is completely voluntary. I understand that I am not required to designate a proxy and I am not required to provide this authorization. I also understand that Sanford will not condition any of my health care treatment, payment or other services on whether I provide this authorization. However, I also understand that if I do not sign this authorization, Sanford is not permitted to provide proxy access to My Sanford Chart account.

This authorization will expire automatically one year from the date of my signature. I may revoke this authorization at any time online through My Sanford Chart or by mailing a written request to the nearest address shown below.

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Sanford: Attention: Release of Information; P.O. Box 2010; Fargo, ND 58122-0007

I understand that if I revoke this authorization, my proxy's access to My Sanford Chart account will end. I understand this will not prevent disclosures already made.

Date: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

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

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

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

**NOTE: Authorization expires one year from the date of signature (above). A new *My Sanford Chart Proxy Authorization Form* must be submitted each year to renew proxy access. You also may deactivate the access of the adult proxy specified above at any time through My Sanford Chart or by providing a written request to your primary clinic.**