



ADULT PROXY DPOA/PERMANENT LEGAL GUARDIAN REQUEST FORM

This Adult Proxy DPOA/Permanent Legal Guardian Request Form (this "Form") is to give an individual (the "Proxy") access information about a patient who lacks decisional capacity under applicable law (the "Patient") through the MyChart patient portal ("MyChart") furnished by Froedtert Health Inc. ("FH") and the Provider Organizations listed below. This Form is to be signed by a person ("Representative") who has been (i) designated as the Patient's health care agent under a durable power of attorney for health care ("Health Care Agent") or (ii) appointed a permanent legal guardian under a court order ("Legal Guardian"). The Proxy receiving access to the Patient's PHI through MyChart may be either the Patient's Representative or another individual that the Representative has authorized to access the Patient's MyChart account.

MyChart is an easy-to-use online tool or mobile app that provides quick and secure access to appointments, medications, and other medical record information of health care services. FH furnishes MyChart for the patients of the following organizations and their respective subsidiaries and other affiliates that use FH's Epic electronic health record system ("Epic EHR System") (collectively, the "Provider Organizations", and together with FH, "we", "us" or "our"):

- Froedtert Memorial Lutheran Hospital, Inc., Community Memorial Hospital of Menomonee Falls, Inc., St. Joseph's Community Hospital of West Bend, Inc., Froedtert & The Medical College of Wisconsin Community Physicians, Inc., West Bend Surgery Center, Froedtert Surgery Center, LLC, Waukesha Surgery Center, LLC, Drexel Town Square Surgery Center, LLC, Menomonee Falls Surgery Center, LLP, Inception Health, LLC, Wisconsin Diagnostic Laboratories, LLC and certain other affiliates of FH (collectively, "FH Affiliates");
- The Medical College of Wisconsin, Inc. ("MCW"); and
- Aspen Orthopedic and Rehabilitation Specialists, S.C. and certain other organizations that contract with FH for the right to use FH's Epic EHR System in their healthcare facilities, physician offices and other locations.

For more information about FH and the Provider Organizations, please visit <https://www.froedtert.com>.

The information available through MyChart is protected health information ("PHI") under HIPAA. The FH Affiliates and MCW use and disclose the Patient's PHI in accordance with the Joint Notice of Privacy Practices available at <https://www.froedtert.com/patients-visitors/patient-privacy/privacy-practices> or by request. The Representative or the Proxy may request the other Provider Organizations' Notices of Privacy Practices from the Provider Organizations.

A Representative may designate himself/herself or another individual as the Proxy to access and use the Patient's MyChart account on the Patient's behalf by completing the Patient and Proxy identifying information below. The Proxy will be able to view PHI and other information available through the Patient's MyChart account, and will be able to take any action through the Patient's MyChart that the Patient would take.

Patient Information: *[Since the Patient cannot make (and understand) his/her healthcare decisions, the Patient will not have his/her own MyChart account. The Patient should NOT complete this Form.]*

Patient's Name:		DOB:	
Address:			
Phone Number:		Last 4 SSN:	

Proxy Information: *[A Proxy that does not already have a MyChart account must fill out his/her own MyChart Account Request Form. The Proxy can only see the Patient's MyChart records by logging into the Proxy's own MyChart account.]*

Email Address:			
Proxy's Name:	Proxy's DOB:	Phone #:	
Street			
City:	State:	Zip:	

Proxy's Relationship to the Patient is as follows:

Legal Guardian of the Patient – The Proxy must attach a copy of the court order appointing the Proxy as the Patient's Legal Guardian and letters of guardianship verifying the Proxy's status as Legal Guardian.

OR

Health Care Agent under an activated Durable Power of Attorney for Healthcare ("DPOA") – The Proxy must attach a copy of the DPOA appointing the Proxy as the Patient's Health Care Agent and two physician certifications verifying the Patient lacks decisional capacity.

OR



**MyChart Authorization for Use or Disclosure of Protected Health Information –
For Adult Proxy DPOA/Permanent Legal Guardian Request Form**

Patient's Name:		DOB:	
Address:			
Phone Number:		Last 4 SSN:	

The undersigned representative (“Representative”), either a permanent legal guardian under a court order (“Legal Guardian”) or health care agent under a durable power of attorney for health care (“Health Care Agent”), of the patient (the “Patient”) identified in this authorization form (this “Authorization Form”), has requested Froedtert Health Inc. (“FH”) and the Provider Organizations listed below to release the protected health information (“PHI”) in the Patient’s MyChart account to the individual identified in this Authorization Form (“Proxy”).

FH furnishes MyChart for the patients of the following organizations and their respective subsidiaries and other affiliates that use FH’s Epic electronic health record system (“Epic EHR System”) (collectively, the “Provider Organizations”, and together with FH, “we”, “us” or “our”):

- Froedtert Memorial Lutheran Hospital, Inc., Community Memorial Hospital of Menomonee Falls, Inc., St. Joseph’s Community Hospital of West Bend, Inc., Froedtert & The Medical College of Wisconsin Community Physicians, Inc., West Bend Surgery Center, Froedtert Surgery Center, LLC, Waukesha Surgery Center, LLC, Drexel Town Square Surgery Center, LLC, Menomonee Falls Surgery Center, LLP, Inception Health, LLC, Wisconsin Diagnostic Laboratories, LLC and certain other affiliates of FH (collectively, “FH Affiliates”);
- The Medical College of Wisconsin, Inc. (“MCW”); and
- Aspen Orthopedic and Rehabilitation Specialists, S.C. and certain other organizations that contract with FH for the right to use FH’s Epic EHR System in their healthcare facilities, physician offices and other locations.

For more information about FH and the Provider Organizations, please visit <https://www.froedtert.com>.

Representative: *[The Representative must read and sign the following statement.]*

By signing below, the undersigned Representative, understands and agrees that:

- The Representative requests and authorizes the Provider Organizations to release the PHI in the Patient’s MyChart account through MyChart to the Proxy listed on this Authorization Form;
- The name and the address of the Proxy who is authorized to receive and direct the disclosure of the PHI through MyChart is:

Proxy’s Name:			
Relationship to Patient:			
Street			
City:	State:		Zip:

- **Description of the PHI to be released to the Proxy:** All medical record and other information available in MyChart, including, without limitation, information relating to mental illness, alcohol/drug abuse, sexually transmitted diseases, HIV test results, developmental disabilities and genetic testing results;
- **Purpose of Disclosure:** The medical record information and other PHI available in MyChart will be released to the Proxy at the Proxy’s request;
- **Authorization Time Period:** This Authorization Form is effective until the Patient’s MyChart account is inactivated and includes all PHI created or existing on or before the date the Representative signed this Authorization Form, and all PHI created after the date the Representative signed this Authorization Form;
- **Right to Revoke Authorization:** The Representative has the right to revoke this Authorization Form and the Proxy’s access to the Patient’s MyChart account at any time. The Representative may revoke this Authorization Form and the Proxy’s MyChart access by revoking access in writing and mailing it to: Froedtert & Medical College of Wisconsin, Office of Clinical Informatics, 200 Woodland Prime, N74 W1501 Leatherwood Ct, Menomonee Falls, WI 53051. Any revocation will not apply to information that has already been released;
- **Right to Receive Copy of Authorization:** The Representative will receive a copy of this Authorization Form, if signed. The Representative also has the right to inspect or copy the health information disclosed under this

Authorization Form. The Representative may arrange to inspect the health information or obtain copies of the Patient's information by contacting the Health Information Management department at (262) 836-2510;

- **Redisclosure Notice:** If the Proxy or anyone receiving PHI from the Proxy is not a health plan, health care provider or health care clearinghouse subject to HIPAA and other privacy laws, they may further disclose the PHI and it may no longer be protected by such privacy laws; and
- **Right to Refuse to Sign this Authorization:** The Representative may refuse to sign this Authorization Form. The Representative's refusal to sign this Authorization Form will not affect the Patient's ability to obtain treatment from the Provider Organizations. If the Representative refuses to sign this Authorization Form, the Proxy's access to the Patient's MyChart account will not be granted.

X _____ / _____
Representative Signature **Date (Required)**

MyChart® is a registered trademark of Epic Corporation
Medical Records Copy

Place Cadence Label Here