Adult Caregiver & ROI Form

A·R·C MyChart® | Austin Regional Clinic

This MyChart Adult Caretaker & Release of Information (ROI) authorization form will permit Austin Regional Clinic to release your medical information to your designated adult caregiver as designated below. Please read it carefully. This form should be completed by the patient who is authorizing another adult to access his or her medical information in the MyChart record. Completing this form will establish a MyChart account for you and your caregiver (a non-ARC Caregiver will only see the caregiver account). Follow the 3 easy steps below:

1. Complete Form

PATIENT'S INFORMATION: ***ALL FIELDS REQUIRED* Please print clearly.**

Last Name of **Patient**: ________________________________ First Name: ________________ Middle Initial: _____

ARC Medical Record Number (**acquire at clinic**): ______________________ Date of Birth: __________________

Street Address: _________________________________ City: ___________________ State: _____ Zip: _________

Email Address: ____ Best Phone Number: ____________________

Primary Clinic: ____

CAREGIVER INFORMATION: ***ALL FIELDS REQUIRED* Please print clearly.**

Last Name: ____ First Name: _______________ Middle Initial: _____

ARC Patient – Medical Record Number (**acquire at clinic**): ____

Non-ARC Patient – Last Four Digits of Your Social Security Number: __________________________________

Date of Birth: ____

Street Address: _________________________________ City: ___________________ State: _____ Zip: _________

Email Address: ____ Best Phone Number: ____________________

Primary Clinic: ____

2. Sign MyChart ROI Terms and Agreement

I am requesting that the caregiver listed above receive access to my health information that is available in my Austin Regional Clinic MyChart Record. This person is my designated MyChart Caregiver. I authorize Austin Regional Clinic to release the health information contained in my MyChart record to my MyChart Caregiver ***Name: _______________________***. I understand that the medical information in MyChart is obtained from my electronic medical record and may include information from all facilities listed in Austin Regional Clinic's Notice of Privacy Practices. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.I authorize release of any information contained in my MyChart medical record held by Austin Regional Clinic to my designated Caregiver.

I authorize release of this information only through my MyChart record. This form does not authorize release of my medical record to my designated caregiver by other methods or in other forms.

I understand that once information has been disclosed, it potentially may be re-disclosed by the Caregiver and the disclosed information may not be covered by federal privacy protections.

Participation in MyChart and designating a MyChart Caregiver is completely voluntary. I understand that I am not required to designate a MyChart Caregiver and I am not required to provide this authorization. I also understand that Austin Regional Clinic does 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 provide authorization, Austin Regional Clinic is not permitted to provide access to my MyChart record to my designated Caregiver.

*****Flip to complete page 2 of this form*****

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(Terms and Agreement continued)

I may revoke this authorization at any time. I understand that if I revoke this authorization, my designated Caregiver's access to my MyChart record will end but that my revocation does not apply to information already accessed in Mychart in reliance on my authorization. Any patient aged 12 and over can revoke Caregiver access through their MyChart Account under My Account > My Family's Records. I understand any revocation will not affect any disclosures that were made prior to revoking Caregiver access.

I acknowledge that I have read and understand this MyChart Adult Caregiver & ROI authorization form. I hereby affirm I am the patient and Caregiver identified above. I agree to its terms and choose to designate the person named above as my MyChart Caregiver, thereby allowing them access to my MyChart medical record. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

By signing below, I acknowledge that I have read and understand this MyChart Adult Caregiver & ROI authorization form and I agree to its terms.

Signature of Caregiver	Relationship to Patient	Date *(required)*
Signature of Patient/Authorized Person		Date *(required)*
If person other than the patient signs, indicate authority to sign for patient *(e.g., guardian, power of attorney)* and attach documentation:		

NOTE: Authorization is indefinite and will remain active until such a time as you deem necessary to deactivate the access of the proxy specified above by providing a written request to your primary clinic.

3. Submit Completed Form

Return the completed form to the front desk at your ARC clinic.

FOR CLINIC USE ONLY:

Please sign and date processed form prior to forwarding to EMR-Scanning at Admin 290

Approved by:______________________________ Clinic Location:_________________________ Date:__________________

Proxy granted by:___________________________ Department Name: _______________________Date:__________________

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