DuPage Medical Group

WE CARE FOR YOU

MyDMGHealth

ADULT PROXY FORM

Please complete the following information to authorize another adult access to your MyChart account at DuPage Medical Group (DMG). **Please note**: the patient's information will be accessed through the designated proxy's own MyChart account, and both the designated proxy and the patient must sign below.

Fax completed forms to 630-324-2933, e-mail to compliance@dupagemd.com, or mail to DuPage Medical Group, ATTN: HIM, 805 Ogden Ave., Lisle, IL 60532

Patient Information

Name (last, first, middle initial): _____

Date of Birth: _____ Phone Number: _____

Email Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Proxy Information

Name (last, first, middle initial): _____

Date of Birth: _____ Phone Number: _____

Email Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

MyChart Terms and Agreement

- Access to MyChart and proxy designation is provided by DMG as a convenience and is completely voluntary; DMG does not condition health care treatment or payment on its use.
- If I share my username and password with another person, that person may be able to view my health information, as well as information of those to which I have proxy access.
- 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.
- MyChart contains limited information and does not reflect the complete contents of the patient's medical record.
- Activities within MyChart may be tracked and may become part of the medical record.
- DMG has the right to deactivate my access to MyChart at any time for any reason.
- Edward-Elmhurst Health and DMG jointly provide MyChart to improve my coordination of and access to care.
- Information obtained through MyChart and re-disclosed by a designated proxy may not be covered by HIPAA.
- I may revoke this authorization at any time by providing a written request, which will end access to the patient's MyChart record. Revocations will not affect disclosures made prior to processing the request.
- This form does not authorize release of medical information to a designated proxy by other methods or other forms.

By signing below, I acknowledge that I have read and understand the above statements.

_____/_____/_____

Signature of Designated Proxy | Relationship to Patient | Date

I understand and authorize sensitive health information (SHI) related to the following may be disclosed to my designated proxy: sexually transmitted diseases (STDs), mental health, pregnancy, birth control, substance abuse, genetic testing, and physical/sexual abuse. I understand I may revoke this authorization at any time by providing a written request, which will end my proxy's access to my account. Revocations will not affect disclosures made prior to processing the request. By signing below, I acknowledge that I have read and understand the above MyChart Terms and Agreement.

_____/_____/_____

Signature of Patient or Legal Representative | Relationship to Patient | Date