ST. TAMMANY PARISH HOSPITAL
MYCHART PROXY ACCESS REQUEST AND AUTHORIZATION FORM – ADULT

Patient Information

Patient's Name: _____

Patient's Clinic Number: _____

Patient's Street Address:

_____

_____

Patient's Date of Birth: _____

Last Four Digits of Social Security Number:

_____

Proxy Requestor Information

Name of Person Requesting Proxy Access:

_____
Print Name

_____
Signature of Proxy Requestor

Proxy's Date of Birth: _____

Proxy Requestor's E-mail Address:

_____

Proxy Requestor's Telephone Number:

_____

Please check relationship to Patient (Multiple selections accepted):

**** This request MUST be accompanied by a copy of legal paperwork verifying the authority of the patient's personal representative (i.e., court-appointed guardian)**

___ Durable Power of Attorney for Healthcare******

___ Caregiver for competent Senior patient (both patient and person requesting must sign below)

___ Legal Guardian ******

___ Parent
___ Child
___ Sibling
___ Significant Other

___ Spouse
___ Step-Parent
___ Step-Child
___ Other Relationship (Explain):_____

Select the Proxy's Level of Access:

___ Full:
Allows grantee to view your medical information, refill medications, send messages, and schedule appointments on your behalf.

___ Read-Only:
Allows grantee to view your medical information, but cannot communicate on your behalf.

___ Communication-Only:
Allows grantee to send messages and schedule appointments on your behalf, but not to view your medical information.

As the patient/patient's personal representative, I hereby authorize St. Tammany Parish Hospital to release health information on the above patient via St. Tammany MyChart according to St. Tammany MyChart terms and conditions. I understand that this may include the patient's treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnoses. I understand that it is my obligation to notify St. Tammany in the event access circumstances change and that I may discontinue proxy access at any time by contacting MyChart@stph.org

_____ _____
Signature of Patient Date

_____ _____
Signature of Prospective Proxy Date

Please submit this form and any required legal documents by:

E-mail: MyChart@stph.org **Fax: 985-871-5792**

Mail: St. Tammany Parish Hospital | Health Information Management Dept | 1202 S. Tyler Street | Covington, LA 70433

Please note that submittal of this form without accompanying verifying information will delay the processing of this request. Access requests delayed for this reason will remain open for a period of 60 days following receipt of the initial request before being terminated. Once terminated, this form and the online request must be resubmitted.