



Proxy for Adult Application Requiring Legal Documentation of Permanent Legal Guardianship or Durable Power of Attorney for Healthcare

This form must be completed by the individual requesting proxy access to the MyChart record of an adult patient age 16 or older who cannot make his/her health care decisions. The requester must have Durable Power of Attorney for Health Care or be the permanent legal guardian for the patient of Lexington Medical Center and/or its affiliated clinics. The requester must present photo identification and provide copies of the appropriate legal documents.

► Adult Patient Information		
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NAMELAST	FIRST	MIDDLE INITIAL
Date of Birth (MM/DD/YY):	Last Five Digits of Patient's SSN#:	
Street Address:		
City, State, ZIP:		
Phone Number: ()		
► PROXY (Legal Guardian or DPOA) Information		
NAME		
LAST	FIRST	MIDDLE INITIAL
Date of Birth (MM/DD/YY):	Last Five Digits of Proxy's SSN#:	
Street Address:		
City, State, ZIP:		
Phone Number: ()		
My relationship to the patient is as follows (Check One)		
Permanent Legal Guardian of the Patient Proxy must attach a copy of the court order appointing guardian permanent legal guardian of the patient.	and letters of guardianship verifying the proxy's status	as
Activated Durable Power of Attorney for Healthcare (DPOA Proxy must attach a copy of the valid DPOA for Health Care and decisional capacity.	•	icks

By signing below, I acknowledge and agree that:

- I will be using my own MyChart account to access the patient's MyChart account.
- I will comply with the terms and conditions on the MyChart website.
- I have provided the proper documentation authorizing me as a legal representative for this patient, thereby allowing me access to portions of his or her medical record through MyChart.
- When my legal authority to act on behalf of the patient has been inactivated, revoked, terminated or expired, I will immediately notify Lexington Medical Center or the patient's primary physician clinic in writing of the revocation, termination or expiration.
- Even if my legal authority to act on behalf of the patient has not been inactivated, revoked, terminated or expired, my access to the patient's MyChart Account will expire one year from the date the proxy relationship is created in the system. I will then need to complete this form again to obtain access for an additional year.

PROXY SIGNATURE (REQUIRED)	DATE & TIME (REQUIRED)
ELATIONSHIP TO PATIENT (REQUIRED	
FOR STAFF USE ONLY	
1. I have attached copies of all required legal documents.	
2. I have given a photocopy of the signed MyChart Authorization to the patient or the patient's representative	re.
3. I have viewed the proxy's photo ID.	
NAME OF LEXINGTON MEDICAL CENTER STAFF WHO VALIDATED PROXY ACCESS (PLEASE PRINT)	DATE VALIDATED