

**Community Health Network  
Authorization for Access to MyChart  
Proxy Access**

If you would like an individual such as a spouse to be able to access your MyChart account, you must complete this authorization form. This authorization expires 3 years after it is signed. Upon expiration, you must complete a new authorization form, allowing the individual to have continued access to your MyChart account.

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I authorize the disclosure of my protected health information, as described herein. I understand that this authorization is voluntary. I understand that the person I authorize to receive my information through MyChart may redisclose the information and it would no longer be protected by federal privacy laws.

1. I authorize the following person(s) to receive my protected health information, as disclosed by Community Health Network via MyChart.  
Name(s):  
Address:  
Relationship to me:
2. The purpose of the disclosure is to provide access to my electronic medical information through Community Health Network's MyChart.
3. I understand that I may revoke this authorization at any time prior to its expiration by sending a signed and dated letter to the Release of Information department at Community Health Network. This revocation will not have any effect on the information that was released prior to the revocation.
4. If I do not sign this form or if I later revoke my authorization, it will not affect the benefits or services for which I am eligible or that I receive from Community Health Network.
5. This authorization expires 3 years after I have signed this document.

I confirm that I have had the opportunity to read and consider the contents of this authorization and agree to be bound by them.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date of Birth

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