

Adult Proxy Authorization Form

Patient Information	
Patient Name:	DOB:
Phone:	Email:
Street Address:	
City, State, Zip:	

Proxy Information	
Proxy Name:	DOB:
LEGAL SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> X	
Phone:	Email:
Street Address:	
City, State, Zip:	
Access Granted: <input type="checkbox"/> Full: Proxy will have the same access as patient. <input type="checkbox"/> Limited: Proxy can view records but will not be able to message providers or schedule appointments. <input type="checkbox"/> Full Access for Legally Authorized Representative: Proxy will have the same access as patient. Please provide supporting legal documentation.	

The UConn Health MyChart Terms and Conditions are available at:

<https://mychart.uconn.edu/mychart/Authentication/Login?mode=stdfile&option=termsandconditions>

By signing and submitting this form, I acknowledge that I have read and understand UConn Health's MyChart Terms and Conditions and designate the person named above as the patient's Proxy, thereby allowing the identified person to view the patient's protected health information via MyChart.

Patient Signature/Legally Authorized Representative: _____ Date: _____

For proxy activation, email completed form and legal documentation, if applicable, to MyChartProxyHIM@uchc.edu.

