Kennedy Krieger
MyChart Proxy
Authorization for Release of Health Information

Patient Name:____ Phone#: ________________________
(first) (mi) (last)

Birth Date:__________________ Medical Record #: ________________________
(if known)

Address: ____
(street address)

____
(city) (state) (zip code)

I hereby authorize **Kennedy Krieger** to grant the below named individual ("My Proxy") access as specified below to my Kennedy Krieger health information that is available through Kennedy Krieger MyChart ("MyChart"):

Proxy's Name:____ Phone#: ________________________
(first) (mi) (last) (required)

Birth Date:__________________ E-Mail: ____
(required) (required)

Address: ____
(street address)

____
(city) (state) (zip code)

Proxy Access Expiration (check only one):

☐ **Expiration Date: __________________**

☐ **Valid for as long as My Proxy is involved in my care. Note:** If you are checking this box, it is your responsibility to notify Kennedy Krieger that you wish to revoke Proxy access. You may do so by completing a new form with an expiration date.

I understand that:

- This Authorization is voluntary. I am not required to designate a MyChart proxy. My treatment/my child's treatment will not be impacted, whether or not I sign this Authorization.
- This form authorizes access only through MyChart and does not authorize release of my medical record to My Proxy by other methods or in other formats.
- This Authorization is valid for as long as specified above, unless I revoke/withdraw this Authorization. I may revoke/withdraw this Authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to the clinic or department where my Authorization was made or given.
- Once Kennedy Krieger discloses health information as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by My Proxy.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse or other sensitive information.
- Access to MyChart is provided by Kennedy Krieger as a convenience to its patients and that Kennedy Krieger has the right to deactivate access to MyChart at any time for any reason.
- By signing below, I acknowledge that I have read and understand this MyChart Authorization and I agree to its terms.

This Authorization will expire in 30 days if you have not activated your MyChart access within that time period.

Printed Name of Patient/Guardian: ____________________________________

Signature of Patient/Guardian:____ Date: ___________________
(required)

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If you are NOT the patient but are signing on behalf of the patient, the following information will need to be completed. Are you the patient? ☐ Yes ☐ No

I,____, am the
(print representative's name)

Check which applies:

- ☐ Parent with Parental Rights
- ☐ Court Appointed Guardian
- ☐ Legally Appointed Healthcare Agent
- ☐ Medical Power of Attorney

Representative's Signature:____ Date: ____________________
(*required*)

Address: ____
(street address)

____
(city) (state) (zip code)

Phone#: _________________________

****You MUST attach proof of your authority to act on behalf of the patient as checked above (other than parent) ****

This form, along with necessary documentation, may be returned to your Kennedy Krieger provider's office or directly to Health Information Management.

Health Information Management

Fax 443-923-1830
Email releaseofinformation@kennedykrieger.org
Mail 801 N Broadway
Baltimore, MD 21205