



MyCHART ACCESS SELF-AUTHORIZATION

For Age 12 and above

To process your request all sections must be completed. Please print clearly.

For Office use only
 Medical Record # _____

Patient Information:

Patient Name: *last*, _____ *first*, _____ *middle initial*, _____

Date of Birth: _____ Age: _____ Email Address: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

I allow Ridgeview to release my personal health information to me via an online MyChart account. I will be able to access information maintained in MyChart for my personal use.

I understand that:

- This authorization will be valid for as long as I maintain an active MyChart account.
- If I change my mind and no longer want MyChart access, I may let Ridgeview know in writing at any time. This change will become effective no later than the next business day after the date that Ridgeview receives my request and will not apply to information that has already been released before this effective date.
- Ridgeview cannot be responsible for the confidentiality of information released to me, and cannot prevent me from releasing the information to another person. At that time, the information is no longer protected by federal and state privacy regulations.
- If I do not sign this form I will still be treated and payment, enrollment and eligibility for benefits will not be impacted.
- To be valid, this form must be completely filled out, signed, and dated. A photocopy, fax or electronically scanned and transmitted image is the same as the original.
- I can receive a signed copy of this form upon my request.
- To complete the MyChart enrollment process and gain access to a MyChart account, I must activate the account with the code I will be or already have been given. As part of this on-line activation process I will be asked to confirm that I have read and agree to the MyChart Terms and Conditions. I understand that every time I use MyChart I agree to these Terms and Conditions.
- I designate my MyChart account as my preferred method of communications.

 Signature of Patient

____/____/____
 Today's Date

Return form to ROI in HIM Department:

E-mail: proxyform@ridgeviewmedical.org **OR** Fax: 952-442-6037

OR Mail: Attn: ROI, 500 S Maple St, Waconia, MN 55387

PATIENT LABEL