OLMSTED MEDICAL CENTER

OMC MyChart Adult Authorization for Release of Health Information

For OMC Staff Use Only:

Patient MRN: _____

Proxy Create Date/By: _____

Patient Name: _____

Address: _____ **Apt #:** _____
(Street)

_____ **Date of Birth**: _____ **Phone:** _____
(City, State, Zip)

I authorize Olmsted Medical Center to release my health information contained in my OMC MyChart record to my designated proxy, _____ *(insert name of proxy)* via OMC MyChart. This authorization form does not allow the release of information to my designated proxy by other methods or in other forms. I understand this information may include records related to evaluation or treatment of behavioral or mental health, alcohol and drug abuse, and HIV/AIDS.

This authorization is valid for two years from the date signed or on a different time period provided by law or on the date/event specified here: _____.

I understand I have the right to revoke my authorization at any time. I understand that if I revoke this authorization, I must do so by completing OMC's *Revocation of Authorization to Disclose Health Information* form or by sending my revocation request in writing to Olmsted Medical Center, Attn: Health Information Management, 210 Ninth Street SE, Rochester, MN 55904. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that if I revoke this authorization, my designated proxy's access to my OMC MyChart record will be deactivated.

I understand designating an OMC MyChart proxy is completely voluntary. I understand that I am not required to designate a proxy and I am not required to provide this authorization. If I do not provide this authorization, I understand that OMC is not permitted to provide my designated proxy access to my health information via OMC MyChart. I understand any release of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I may contact OMC's information privacy officer. I understand OMC will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand this is a legal document and by signing, I agree that I understand and accept the terms on this form.

_____ _____/_____/_____
Signature of Patient or Authorized Representative Date of Signature

_____ _____
Printed Name of Authorized Representative Relationship to Patient or Description of Legal Authority
(Documentation of legal authority required - please submit)

Submit completed form to Olmsted Medical Center, Attn: Health Information Mgmt, 210 Ninth Street SE, Rochester, MN 55904.

Translated Versions – Consent – OMC MyChart Adult Authorization for Release of Health Information
English – 1012009 Spanish – 1013109 Somali – 1020109