El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

2500 Grant Road, Mountain View, CA 94040-4378
Telephone: (650)988-7462 | Fax: (650)988-8246

Patient Label

MyCare:
Adult Proxy Request Form

To request access to the MyCare record of an adult patient whose medical care you help manage, please complete this form. Both the patient and proxy representative must sign this form.

In addition, the patient must authorize the release of records via MyCare by completing the authorization for "Adult Proxy Release of Information Authorization" form

Patient Information:

Patient Name:		
Address:		
City:	State:	Zip:
Date of Birth:		

Proxy Information:

Representative Name:		
Address:		
City:	State:	Zip:
Phone:	Date of Birth:	
Email address:		

Your relationship to patient*:

☐ Durable Power of Attorney ☐ Conservator ☐ Other:_____

*Legal documents may be required to validate relationship, e.g., birth certificate, guardianship/ conservatorship appointment, durable power of attorney

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MyCare Terms and Conditions:

I understand that:

- MyCare is intended as a secure online source of confidential medical information. If I share my MyCare ID and password with another person, that person may be able to view my or my child's health information, and health information about someone who has authorized me as a MyCare proxy.
- It is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.
- MyCare contains selected, limited medical information from a patient's medical record and does not reflect the complete contents of the medical record.
- My activities within MyCare may be tracked by computer audit and that entries that I make may become part of the patient's medical record.
- MyCare is provided by El Camino Hospital as a convenience to its patients. El Camino Hospital has the right to deactivate access to MyCare at any time for any reason.
- MyCare is voluntary and I am not required to use MyCare or to authorize a MyCare proxy.
- The authorization form may be revoked in writing at any time, except to the extent that the information has already been accessed. I must submit my revocation to El Camino Hospital.

Mail completed form to:

El Camino Hospital
Attention: HIM Dept. (Medical Records)
2500 Grant Road
Mountain View, CA 94040

- OR -

Fax to: 650-988-8246

By signing below, I acknowledge that I have read and understand the requirements for designating the person named above as my MyCare Proxy, thereby allowing them access to my MyCare medical record.

_____ _____
Patient/Legal Representative Signature Date

_____
Relationship to Patient

OFFICE USE ONLY:		
Patient relationship verified by:_____	Proxy access approved: ☐Yes ☐No	Activation Letter Sent : ☐Yes ☐No Date Sent:_____