My Sanford Chart

Adult/Teen Proxy Form

SANFORD

Fill out this form to give someone else consent to see your My Sanford Chart Record. This person is called your Proxy. Send this form by mail to the address shown below after the form is notarized. A notary is a person with a special license to watch you sign legal forms.

Send this form to: Sanford Business Center, Route 5228, 2200 E Benson Road Sioux Falls, SD 57104

About the Patient/Member: (All sections required-please print clearly)

Name (last, first, middle initial)_____ Date of Birth_____

Last 4 digits of Social Security Number:_____ Email:_____

Phone Number:_____ Member ID Number (if applicable):_____

About the Proxy: (All sections required - please print clearly.)
Complete for the person getting access to the Patient/Member's My Sanford Chart record.

Name (last, first, middle initial)_____ Date of Birth_____

Last 4 digits of Social Security Number:_____ Email:_____

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

Phone Number:_____ Member ID Number (if applicable):_____

I ask that my Proxy (whose name is above) have access to my complete medical and/or health insurance record including My Sanford Chart and any medical record sharing platforms linked to My Sanford Chart. I understand the data in My Sanford Chart may include medical, billing and insurance information.

I also give consent for my Proxy to do these things for me:

- See and send messages to my healthcare team or insurance.
- Update my name, other personal data, and payment or insurance details.
- See who has accessed my medical or health insurance record through My Sanford Chart.
- Get copies of any part of my medical or health insurance record.

I understand and agree:

- My Proxy may have access to behavioral health and alcohol or drug treatment records and/or claims.
- Records given to my Proxy may be given to others and no longer protected.
- My Proxy may have access to non-Sanford medical records incorporated into My Sanford Chart through my use of linked medical record sharing platforms, exchanges, and third-party applications.

Naming a Proxy is my choice and not required. I do not have to give this consent. I will receive care even if I do not sign this consent. I understand that if I do not sign this, access will not be given to my Proxy. If I am over 18, this consent expires 5 years from the date of my signing. If I am a minor, it will expire when I turn 18.

I may take away consent through My Sanford Chart or by mail to the address above. I understand that if I take away consent, my Proxy's access to my health record will end. I understand this will not prevent the release of data already given. I have read and understand this form.

_____/_____/_____

Signature of Patient (or authorized person) (Required) **Relationship to Patient** **Date/Time**

_____/_____

Notary (if mailed or patient not present) (Required) **Date/Time**