My Sanford Chart
Adult/Teen Proxy

SANFORD

Please fill out this form to give someone else consent to see your My Sanford Chart patient record. This person is called your Proxy. Bring it with you to your next visit or mail it to the address shown below. If you choose to mail this form, it must be notarized first. A notary is a person with a special license to watch you sign legal forms.

Mail this form to: Sanford Health, Route 6190, PO Box 5039, Sioux Falls, SD 57117-5039

About the Patient: (All sections required – please print clearly)

Name (last, first, middle initial) _____ Date of Birth: _____

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

Phone Number: _____

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

Name (last, first, middle initial) _____ Date of Birth: _____

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

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

Phone Number: _____

I ask that my Proxy (whose name is above) have access to my complete patient record including My Sanford Chart. I understand the data in My Sanford Chart may include all my medical and billing data. I also give consent for my Proxy to do these things for me:

- See, make, and check-in for appointments
- See and send messages to my health care team
- Update my name, address, personal data, and payment or insurance details
- See who has accessed my medical record through My Sanford Chart
- Get copies of any part of my medical record. Have my medical record sent to any third party.

I understand and agree:

- My Proxy may have access to behavioral health and alcohol or drug treatment records.
- Records given to my Proxy may be given to others and no longer protected.

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**

_____ / _____ / _____

Notary (if mailed or patient not present) **Date**