MYBMGCHART
PROXY ACCESS REQUEST (ADULT)

Please read this form carefully before signing. This authorization will permit Buffalo Medical Group to release portions of your electronic medical record information to the person listed on page 2 of this form. I understand that use of MyBMGChart is voluntary. I am not required to use MyBMGChart or authorize a proxy.

Type of information to be disclosed: I understand that this authorization may cover disclosure of information relating to alcohol or drug abuse, pregnancy, sexually transmitted diseases, genetic testing, psychiatric care and/or confidential HIV-related information. In the event any of your medical information contains such information, by signature at the end of this form, you specifically authorize its release to the person (proxy) named below.

Method of Disclosure: My medical information will be disclosed to the person listed below through MyBMGChart.

Redisclosure: I understand that if I authorize the release of HIV-related information, the recipient is prohibited from redisclosing such information without my authorization, unless permitted to do so under state or federal law. I understand that once my information is released pursuant to this Authorization, it could be disclosed to others and would no longer be protected by federal privacy regulations. If I have a concern about HIV-related information, I may contact the NY State Division of Human Rights at 1-800 523-2437.

Expiration: This authorization for release of information to my proxy will expire only upon my written revocation or when Buffalo Medical Group is notified on my death or the death of the person I have authorized to access MyBMGChart.

Revocation: I can change my mind and revoke this proxy authorization at any time, except to the extent that anyone has already taken action based on this authorization. I can revoke my proxy authorization online through MyBMGChart or I can send a written request to: Buffalo Medial Group _____ Department, _____ . I understand that Buffalo Medical Group can also revoke access to MyBMGChart for patients or proxies at any time and for any reason.

Durable Authorization: I acknowledge that this is a durable authorization that will not expire in the event I become incapacitated or incompetent.

Submitting the Proxy Form: Give this form to your Physician's office or send the form to _____ . Please allow two weeks for processing. You will receive a MyBMGChart message once the proxy form has been processed.

MYBMGCHART
PROXY ACCESS REQUEST (ADULT)

This form is an authorization that will permit Buffalo Medical Group to release your (the patient) electronic medical record information to the adult that you have designated and authorized to access your MyBMGChart account. You have the opportunity to opt out of or revoke the access at any time.

To request access to the record of an adult through MyBMGChart, please complete this form. The patient whose information you are requesting to access must sign this form. Please note that the patient's chart will be accessed through your MyBMGChart account. Return completed forms to the health care provider from whom this form was obtained.

IS THE PROXY A CURRENT PATIENT OF BUFFALO MEDICAL GROUP? Yes or No (circle one)

Your (Proxy) Information (All sections required – Please print clearly.)

This section should be completed by the individual requesting access to another adult's MyBMGChart record.

Name (*last, first, middle initial*) _____Date of Birth _____
Street Address: _____ City:_____ State: _____ Zip:_____
Phone Number: _____ Email: _____
Social Security #_____

Patient's Information (All sections required – Please print clearly.)

Complete this section with information about the patient whose MyBMGChart record you're requesting to access.

Name (*last, first, middle initial*) _____Date of Birth _____
Street Address: _____ City:_____ State: _____ Zip:_____
Phone Number: _____ Email: _____MRN _____

MyBMGChart Terms and Conditions

The use of MyBMGChart is governed by the MyBMGChart Terms and Conditions and the MyChart Proxy Terms and Conditions of Use, a copy of which may be accessed when you sign in to your MyBMGChart account and whose terms are incorporated herein. By signing below, you agree to be bound by the MyBMGChart Terms and Conditions and the MyChart Proxy Terms and Conditions of Use. If, for any reason, you do not agree to be bound by the MyBMGChart Terms and Conditions and the MyChart Proxy Terms and Conditions of Use, MyBMGChart proxy access will immediately be terminated.

_____/_____/_____
Your (Proxy) Signature – (Required) Relationship to Patient Date

I hereby designate the person named above as my MyBMGChart Proxy, thereby allowing him/her access to my MyBMGChart medical record.

_____/_____/_____
Signature of Patient or Authorized Person – (Required) Relationship to Patient Date

I hereby approve this proxy access:

_____/ _____
Physician Signature Date