Baptist Health

AUTHORIZATION TO ACCESS
MYCHART PROTAL
FOR OTHERS INVOLVED
IN MY CARE

Patient Name_____ Date of Birth_____

I hereby request access to MyChart Portal for the following person:

Person needing access to patient's MyChart account:

Name: _____

Last Four Digits of SS#: _____

Date of Birth: _____ / _____ / _____

Telephone #:_____

Email: _____

Current Mailing Address:

_____

City, State, Zip Code

Does the person needing access already have a MyChart Portal account? Yes No

Please, Mail, or Fax this form to:

BAPTIST HEALTH Medical Center - Little Rock
ATTN: Medical Records Department
9601 Baptist Health Drive
Little Rock, AR 72205-7299
Phone: 501-202-1914
Fax: 501-202-1249

I understand that I may revoke this authorization at any time by sending written notice to the MyChart email address indicated above. I understand that any release which has been made prior to such revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality

I understand that my ability to receive treatment is not conditioned on my signing this Authorization.
NOTICE: Once your PHI has been disclosed in accordance with this authorization, it may be re-discovered to individuals or organizations that are not subject to HIPAA regulations, which means the information may no longer be protected by HIPAA.

This authorization will automatically expire in two years.

Upon receipt of completed form(s), acknowledge of account activation will be mailed to requestor via either U.S. Postal Service.

_____ _____
Signature of Patient or Legal Representative Date Relationship, if not the patient

_____ _____
Witness Date Witness's Address