FirstHealth OF THE CAROLINAS

Patient Authorization -
Proxy /Authorized Representative
MyChart Access

1PROX001

8181.99.01.fhc Sunset Date: 5/2027

Place Patient Label
Inside This Box

PATIENT AUTHORIZATON - Proxy Access to my FirstHealth of the Carolinas MyChart Account

I authorize and request FirstHealth of the Carolinas to grant my authorized representative as designated below ("Authorized Representative") access to electronic protected health information, including clinical and guarantor billing information, maintained in my FirstHealth Of the Carolinas online Patient Portal record accessed through MyChart (hereafter referred to as "MyChart").

Authorized Representative (Printed Name):_____ **DOB:**_____

Relationship:_____ Email:_____
Address:_____ City:_____
Zip Code:_____ State:_____ Preferred Phone:_____ Cell ☐ Home ☐

Electronic Protected Health Information in my online chart may include but is not limited to:

Hospital Admissions	Diagnostic Test Results	Medications/Allergies
Diagnoses/Procedures	Medical History	Secure Messaging
Physician/Provider Reports	Current Health Issues	Billing & Insurance

I understand that:

- Information in MyChart may include mental health, substance abuse or STD diagnosis, treatment or medications
- I may ***revoke*** this authorization at any time by contacting the Patient Privacy Office at FirstHealth of the Carolinas at 1 (866) 898-8891. Such revocation shall not affect disclosures made prior to the revocation.
- Information disclosed pursuant to the authorization may be subject to ***redisclosure*** by my Authorized Representative and may no longer be protected by the HIPAA Privacy Rule.
- This authorization is voluntary. If I do not sign or if I revoke this authorization, First Health of the Carolinas will still provide treatment to me and will seek payment for services provided.
- This authorization is valid unless and until I revoke the Authorized Representative's access.
- Access to my protected health information by my Authorized Representative requires that I maintain an active online Patient Portal account.

Expiration:

I understand that by granting access to my Authorized Representative, they are required to agree to comply with Terms and Conditions required for online access. Should my Authorized Representative not accept and comply with the Terms and Conditions, I understand that FirstHealth may deny my Authorized Representative access or revoke their access to MyChart.

Signatures:

_____ _____
(Signature of Patient) ***(Date / Time)***

_____ _____
(Printed Full Name of Patient) ***(Date of Birth)***

Signature Witness:_____ **Date/Time:**_____

Original: Patient Chart
RETURN THIS FORM VIA E-MAIL (mychartsupport@firsthealth.org), FAX (910-235-7808), or mail to FirstHealth of the Carolinas Privacy Office PO Box 3000, Pinehurst, NC 28374