Methodist Le Bonheur Healthcare

oneChart – Physician Proxy Form

Purpose: To delegate Practice/Site Manager to maintain Provider Group List and grant oneChart access to other office staff.

Please print and complete the required fields (*). Incomplete forms will not be processed.
Email forms to: posupport@myhealthchoice.com

***Practice Group Name**: _____

Provider Group List (if different than name listed above): _____

***Primary Address**: _____ ***City/ State/ Zip:** _____/_____/_____

***Primary Phone:** _____ ***Primary Fax:** _____ ***Primary Email Address:** _____

I agree to be included in a provider group listing, containing all of my physician partners within my practice, which will be made available to my office staff to view clinical information for Methodist Le Bonheur patients. This list will also be available to physician partners for coverage and rounding within Methodist Le Bonheur Hospitals.

I delegate my Practice/Site Manager _____to maintain the Provider Group List and grant access for other office staff to view protected health information for Methodist Le Bonheur patients.

I have read and understand the "Confidentiality Agreement Regarding Access to Electronic Medical Records" (the "Agreement") located on www.methodistmd.org in its entirety. By signing below, I hereby adopt the Agreement and agree to all the obligations described for the practice members as outlined in the Agreement, and any amendments agreed upon by the Practice member.

***Physician's Name** _____ ***Email Address** _____
(Please Print)

***Signature** _____ ***Date** ___/___/___

I agree to grant access for other office staff to view protected health information for Methodist LeBonheur patients.

I have read and understand the "Confidentiality Agreement Regarding Access to Electronic Medical Records" (the "Agreement") located on www.methodistmd.org in its entirety. By signing below, I hereby adopt the Agreement and agree to all the obligations described for the practice members as outlined in the Agreement, and any amendments agreed upon by the Practice member. I agree to report any and all violations to the "Confidentiality Agreement Regarding Access to Electronic Medical Records" (the "Agreement") by completing a "Violation Form" located on www.methodistmd.org

***Practice/Site Manager's Name** _____ ***Email Address** _____
(Please Print)

***Signature** _____ ***Date** ___/___/___