Nebraska Medicine

CONSNT

PT NAME

MR #

This form is used to: Grant a Health Care Agent or Guardian access to the One Chart | PATIENT account of a minor or incapacitated adult

This form may be used by:

(1) The legal guardian of a minor patient; and/or
(2) the personal representative of an incapacitated adult with legal authority to make health care decisions on behalf of the incapacitated adult patient

To request access to One Chart | PATIENT as a personal representative of a patient, as described above, please complete this form. **Please attach legal documents proving guardianship or other legal authority such as Durable Power of Attorney for Health Care.** Your request will not be processed without the legal documents. Please allow 14 business days upon receipt of a complete application for processing.

Patient Information: (All sections required – please print clearly.)
Complete this section with information about the patient whose ONE CHART record you are requesting to access.

Name *(last, first, middle initial)* _____

Date of Birth:_____ Last 4 digits of SSN:_____

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

Email Address:_____ Phone Number:_____

Primary Clinic: _____

GUARDIAN OF MINOR PATIENT/HEALTH CARE AGENT FOR INCAPACITATED ADULT PROXY FORM

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Proxy Information: (All sections required – please print clearly.)
This section should be completed by the individual requesting access on behalf of another individual.

Name *(last, first, middle initial)* _____

Date of Birth:_____ Last 4 digits of Social Security #:_____

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

Email Address:_____ Phone Number:_____

Please indicate basis of legal authority to act on behalf of patient for health care (copy of legal documentation must be supplied):

___ Health Care Agent (attach Durable Power of Attorney for Health Care)

___ Legal Guardian (attach Guardianship order)

One Chart | PATIENT Attestation

- I certify that I am the legally authorized representative of the above-named patient, with legal authority to make health care decisions on behalf of the above-named patient, and all information I have provided is correct.
- I acknowledge that it is my responsibility to keep my One Chart | PATIENT log-in information confidential or risk others having access to the confidential information contained therein.
- I understand that One Chart | PATIENT contains selected, limited medical information from a patient's medical record and that One Chart | PATIENT does not reflect the complete contents of the medical record. I also understand that a paper copy of a patient's medical record may be requested from my provider.
- I understand that my activities within One Chart | PATIENT may be tracked and that entries I make may become part of the medical record.
- I further agree to abide by the Terms and Conditions of use of ONE CHART which I have the responsibility to review.

_____

Signature of Legal Representative *(Required)* **Date**

Return this Form and legal documentation to: 989100 Nebraska Medicine
Omaha, NE 68198-9100

GUARDIAN OF MINOR PATIENT/HEALTH CARE AGENT FOR INCAPACITATED ADULT PROXY FORM