Access to Another Adult’s Online Medical Record

Requirements and Procedures

Adults who help manage the medical care of another adult, can access the online medical record of the patient, if the patient authorizes.

Requirements for online access to a patient’s medical record:

- Individual requesting access must have signed consent from the patient
- Authorization Form must be completed and signed
- Each individual requesting access must have their own MyHealth Online account or a MyHealth Online account will be established by Fletcher Allen staff

I understand that:

- I must have a MyHealth Online account or an account will be established for me
- I must log in to MyHealth Online with my own Username and Password
- In Medical Information tab, I must click on ‘Family Records’ to access a patient’s online record
- I agree to abide by the terms and conditions on the MyHealth Online site
- MyHealth Online is not to be used in an emergency

Access to a patient’s record is revoked when the patient or physician submits a request or revokes access online. Fletcher Allen reserves the right to revoke online access to medical information at any time. Access to a patient’s record is also automatically terminated upon the patient’s death.

Communications on behalf of the patient must be sent from the patient’s record and responses will be received in the patient’s record. MyHealth Online email alerts will be sent to the email address entered in the patient’s record.

When signed into another person’s online medical record, you will see a message at the top of the page listing the patient’s name and alerting you that you are viewing their record. This will serve as a visual indication that you are in the proper record.

If you have a MyHealth Online account, you will receive a MyHealth Online in your Medical Message Center when access to the patient’s record is available, typically 5 to 7 business days after the signed authorization form is received.

If you do not have a MyHealth Online account, you will receive a MyHealth Online Activation Invitation Letter with instructions on how to create one. If you do not activate your account within 60 days after receiving your MyHealth Invitation Letter, your child’s account will be inactivated. Please promptly activate your account.
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Authorization Form

Please enter Patient’s information below:

| Patient’s Name: _______________________________ | Fletcher Allen Medical Record # (MRN): ____________ |
| Address: ______________________________________ | Date of Birth: _________________________________ |
| ______________________________________________ | Gender: □ Male □ Female |

To be notified when new messages about your child’s care are sent to MyHealth Online please list an email address:


I agree to allow the individual, named below, MyHealth Online access to my medical information currently available and that may become available as a result of future medical care. I understand I may revoke this access at any time.

☐ I do NOT permit access to any Test Results (check box).

| Date: _______________ | Patient Signature: ______________________________ |
| Date: _______________ | Witness Signature: _____________________________ |

Please enter information on the adult who is being authorized to access your online medical record below:

| Name: _______________________________ | Fletcher Allen Medical Record # (MRN): ____________ |
| Address: ______________________________________ | Date of Birth: _________________________________ |
| ______________________________________________ | Gender: □ Male □ Female |

Former Name(s) – e.g. maiden name: ____________________________

Relationship to patient: □ Son □ Daughter □ Spouse □ Other
If Other, please specify: ______________________________________

Do you (adult who is being given access) have an active MyHealth Online account? □ Yes □ No □ Don’t Know

I have read and understand the requirements and procedures regarding accessing a patient’s medical record information online as provided on the document titled “Access to Another Adult’s Online Medical Record.”

I certify that all information I have provided is correct. I hereby request access to this patient’s online medical record.

| Date: _______________ | Signature: ______________________________ |
| Date: _______________ | Witness Signature: _____________________________ |

For security reasons, please bring completed form to the Patient’s Fletcher Allen Doctor’s Office for processing.

Office Use Only:
Active Code Generated □  Signatures: □ Patient □ Caregiver
Proxy Linking Done □  Active Code Letter: □
Proxy Access Granted Letter □  Patient Notification Letter □