My UC Health Sign-Up Form for Child(ren)

****Use this form for a parent who wishes to access the health information of his or her child(ren) under the age of 13 in My UC Health.**

Parent Information: (please print clearly).

Your Name: _____ DOB _____
(last, first, middle initial)

_____
(Street Address) (City) (State) (Zip Code)

Child(ren) Information: (please print clearly and complete information for each child that is a patient of UC Health). Your

Child's Name: _____ DOB _____
(last, first, middle initial)

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(last, first, middle initial)

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(last, first, middle initial)

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(last, first, middle initial)

Your Child's Name: _____ DOB _____
(last, first, middle initial)

** If your child is under the age of 13, you will be granted full access to your child's My UC Health record. Except under special circumstances, UC Health will terminate access to My UC Health by Parent(s)/Legal Guardian(s) when the patient turns 13 years old. For minor patients between the ages of 13 and 18, a determination can be made after consultation with the minor patient's physician whether the parent or legal guardian will have proxy access to the minor's My UC Health account.

Please return completed form(s) to the office of the patient's provider or mail to the following:

UC Health – Epic Admin
3200 Burnet Avenue, 5 BAP
Cincinnati OH 45229

My UC Health Proxy Form &
Patient Authorization to Release Protected Health Information to Proxy

****Use this form for adult patients who wish to grant proxy access to other adults.**

Patient's Information: (**All fields required - please print clearly)**.

Complete this section with information about the patient whose My UC Health record will be accessed by the proxy.

Name _____ Date of Birth:_____

(*last, first, middle initial)*

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

Phone Number_____ Email: _____

Adult Proxy Information: (**All fields required - please print clearly)**.
Complete this section with information about the adult who will be designated as the patient's proxy.

Name _____ Date of Birth:_____

(*last, first, middle initial)*

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

Phone Number_____ Email: _____

I _____ (patient name) permit UC Health to release protected health information through My UC Health to_____ (proxy name). I understand that by permitting another person proxy access to My UC Health, he or she will view the same information that I may view myself.

I understand that once my records have been released to my proxy they may be re-disclosed by the proxy and will no longer be protected by federal privacy regulations.

I understand that protected health information that is released through My UC Health to my proxy may include information related to the treatment, diagnosis or testing of alcohol or drug abuse, **drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), and/or test for antibodies to the AIDS virus (HIV).**

I further understand that the information that is released through My UC Health to my proxy may include information related to medications and use of contraception, sexually transmitted diseases, and/or any history of abortion.

I understand that I can terminate my Authorization to release information to my proxy at any time by informing a member of my care team verbally or in writing at my provider's office or by sending notice in writing to UC Health, Attn: My UC Health HIM Department, 3200 Burnet Avenue, Cincinnati, OH 45229. This termination of Authorization will not apply to records that were previously released.

I understand that I may refuse to sign this Authorization and it will not affect my ability to obtain treatment. If I refuse to sign this Agreement, proxy access will not be granted to the above-named adult at this time.

[SIGN ON NEXT PAGE]

PATIENT MUST SIGN BELOW:

I understand that my use of My UC Health is voluntary and I am not required to use My UC Health or to authorize a My UC Health proxy. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO CONTACT UC HEALTH TO REVOKE THE PROXY STATUS WHEN I NO LONGER WANT THE PERSON I DESIGNATED TO HAVE ACCESS TO MY MY UC HEALTH INFORMATION. By signing below, I acknowledge that I have read and understand this My UC Health Proxy Form and Patient Authorization to Release Protected Health Information to Proxy. I agree to its terms and choose to designate the person named above as my My UC Health proxy, thereby allowing him or her access to my My UC Health medical record.

_____/_____

PATIENT SIGNATURE/Legal Guardian Date (Required)

Printed name of Patient's Legal Guardian, if applicable:_____

*Legal documentation of guardianship if applicable must accompany this Proxy Form. This document must be scanned into the patient's electronic medical record.

PROXY MUST SIGN BELOW:

By signing below, I acknowledge that I have read and understand this My UC Health Proxy Form and I agree to its terms. I understand that my proxy access can be revoked at anytime by the patient or UC Health for any reason, including misuse of My UC Health by me.

_____/_____

PROXY SIGNATURE Date (Required)

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Cincinnati OH 45229