ROICOR

UC Health

MY UC HEALTH (MYCHART) **CHILD** PROXY SIGN-UP FORM

LOCATION: ☐ Daniel Drake Center ☐ University of Cincinnati Medical Center ☐ West Chester Hospital ☐ UC Physicians

For legal compliance purposes, a parent or guardian must complete and submit this form to access the health information of their child(ren)/dependents under the age of 13 via My UC Health (MyChart). All fields are required. See return options below.

Parent/Guardian (Proxy) Information: (please print clearly).

Parent/Guardian Name:_____ DOB: _____
(last, first, middle initial)

Street Address: _____City: _____State: _____Zip: _____

Phone Number: _____Email: _____

Last four of SSN: _____ (required for creation of MyChart account if proxy does not have an active MyChart Account)

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

Name of Child/Dependent:_____ DOB: _____
(last, first, middle initial)

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(last, first, middle initial)

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(last, first, middle initial)

Name of Child/Dependent:_____ DOB: _____
(last, first, middle initial)

Name of Child/Dependent:_____ DOB: _____
(last, first, middle initial)

** If your child/dependent is under the age of 13, you will be granted full access to their My UC Health (MyChart) record. Except under special circumstances, UC Health will terminate access to MyChart by Parent(s)/Legal Guardian(s) when the patient turns 13 years old.

PARENT/GUARDIAN (PROXY) MUST SIGN BELOW:

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

_____/_____
PARENT/GUARDIAN (PROXY) SIGNATURE Date (Required)

RETURN SIGNED FORM TO:

Mail: UC Health, 3200 Burnet Avenue, BAP Information Center, Cincinnati, OH 45229
Email: MyUCHealth@uchealth.com
Fax: 513-585-6383

ROICOR

MY UC HEALTH (MYCHART) **TEEN** PROXY FORM AND PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO PROXY

For legal compliance purposes, a parent or guardian must complete and submit this form to access the health information of their child(ren)/dependents between the ages of 13 and 17 via My UC Health (MyChart). All fields are required. See return options below.

Patient (Teen) Information:
Complete this section with information about the patient whose My UC Health (MyChart) record will be accessed by the proxy.

Name: _____ Date of Birth: _____ Last 4 of SSN: _____
(last, first, middle initial)
Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Parent/Guardian (Proxy) Information:
Complete this section with information about the adult parent or legal guardian 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: _____

Last four of SSN: _____ (required for creation of MyChart account if proxy does not have an active MyChart Account)

I _____ (patient name) permit UC Health to release protected health information through MyChart to

_____ (proxy name). I understand that by permitting another person proxy access to MyChart, 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 (MyChart) to my proxy may include information related to the treatment, diagnosis or testing of alcohol or drug use, **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 (MyChart) 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 sending notice in writing via:

Mail: UC Health, 3200 Burnet Avenue, BAP Information Center, Cincinnati, OH 45229
Email: MyUCHealth@uchealth.com
Fax: 513-585-6383

This termination of Authorization will not apply to records that were previously released. [SIGN ON NEXT PAGE]

ROICOR

MY UC HEALTH (MYCHART) **TEEN** PROXY FORM AND PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO PROXY

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.

** If your child is between ages 13-17, you will be granted admin only access to your teen's MyChart record. Except under special circumstances, UC Health will terminate access to MyChart by Parent(s)/Legal Guardian(s) when the patient turns 18 years old. The patient may choose to grant additional access to the proxy from their MyChart account.

PATIENT MUST SIGN BELOW:

I understand that my use of MyChart is voluntary and I am not required to use MyChart or to authorize a MyChart 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 MYCHART INFORMATION. By signing below, I acknowledge that I have read and understand this MyChart 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 MyChart proxy, thereby allowing him or her access to my MyChart medical record.

_____/_____

PATIENT SIGNATURE/Legal Guardian Date (Required)

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

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

PARENT/GUARDIAN (PROXY) MUST SIGN BELOW:

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

_____/_____

PARENT/GUARDIAN (PROXY) SIGNATURE Date (Required)

RETURN SIGNED FORM TO:

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ROICOR

MY UC HEALTH (MYCHART) **ADULT** PROXY FORM AND PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO PROXY

Use this form for adults (age 18 or older) or patients with diminished capacity who wish to grant proxy access to other adults.

Patient Information: (All fields required - please print clearly).
Complete this section with information about the patient whose MyChart record will be accessed by the proxy.

Name: _____ Date of Birth: _____ Last 4 of SSN: _____
(last, first, middle initial)
Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

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: _____

Last four of SSN: _____ (required for creation of MyChart account if proxy does not have an active MyChart Account)

I _____ (patient name) permit UC Health to release protected health information through MyChart to

_____ (proxy name). I understand that by permitting another person proxy access to MyChart, 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 MyChart to my proxy may include information related to the treatment, diagnosis or testing of alcohol or drug use, **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 MyChart 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 sending notice in writing via:

Mail: UC Health, 3200 Burnet Avenue, BAP Information Center, Cincinnati, OH 45229
Email: MyUCHealth@uchealth.com
Fax: 513-585-6383

This termination of Authorization will not apply to records that were previously released. [SIGN ON NEXT PAGE]

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MY UC HEALTH (MYCHART) **ADULT** PROXY FORM AND PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO PROXY

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.

PATIENT MUST SIGN BELOW:

I understand that my use of MyChart is voluntary and I am not required to use MyChart or to authorize a MyChart 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 MYCHART INFORMATION. By signing below, I acknowledge that I have read and understand this MyChart 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 MyChart proxy, thereby allowing him or her access to my MyChart medical record.

_____/_____

PATIENT SIGNATURE/Legal Guardian Date (Required)

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

*Legal documentation of guardianship or power of attorney 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 MyChart Proxy Form and I agree to its terms. I understand that my proxy access can be revoked at any time by the patient or UC Health for any reason, including misuse of MyChart by me.

_____/_____

PROXY SIGNATURE Date (Required)

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