Patient Label

UCI Health

PROXY ACCESS TO A CHILD, TEEN, OR ADULT UCI HEALTH MYCHART RECORD

To request access to a patient's MyChart patient web portal record, please complete all pages of this Proxy Access Request and present to your clinic registration staff. Access to the child, teen, or adult's MyChart will be through your MyChart account. The MyChart patient web portal is at: https://my.ucihealth.org/.

Please select from the following Proxy Access options and follow the instructions. A separate form is required for each patient for whom access is requested.

☐ **Child Proxy** – If the patient is a minor between the ages of 0-11, the proxy will be granted full access to the minor patient's MyChart record until the child reaches age 12. **Complete sections 1, 2 and 3 of this form.**

☐ **Teen Proxy** – If the patient is a minor between the ages of 12-17, access is limited to ensure privacy for our patients in accordance with the California Confidentiality of Medical Information Act (CMIA). NOTE: The limitations in place for MyChart Proxy Access do not affect any legal right you have to access the patient's records by other means. To request a paper copy of the patient's chart, contact Health Information Management at (714) 456-5670. **Complete sections 1, 2, and 3 of this form.**

☐ **Enhanced Teen Proxy** – If the patient is a minor between the ages of 12-17, you will be granted standard Teen Proxy access, as well as the ability to make and cancel appointments, message providers, and review all clinical info including notes and test results. **Complete sections 1, 2, 3 and 4 of this form.**

☐ **Adult Proxy and Emancipated Minor Proxy** – If the patient is an adult, 18 or older, consent from the patient (or authorized legal guardian) is required for access to the patient's MyChart record. **Complete sections 1, 2, 3 and 4 of this form.**

SECTION 1 **Proxy Information** (All items required. Please print clearly.)

Name _____
Last First Middle Initial

Social Security Number (last 4 digits) _____ Date of Birth _____

_____
Street Address City State Zip Code

_____
Phone Number Email Address Relationship to Patient

SECTION 2 **Patient Information** (All items required. Please print clearly.)

Please provide the following information for the person for whom proxy access is requested.

Name _____
Last First Middle Initial

Social Security Number (last 4 digits) _____ Date of Birth _____

_____
Street Address City State Zip Code

_____
Phone Number Email Address

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USER ACKNOWLEDGMENT OF TERMS AND CONDITIONS FOR USE OF UCI HEALTH MYCHART

You are requesting access to UCI Health (UCIH) MyChart, which contains the online health information for you or another person. By signing below, you represent that you have the legal right to access the information contained in the patient's medical record.

1. If you are a parent or other legally authorized representative of the patient, you certify and represent that no court has terminated your parental or legal rights with respect to the patient or otherwise restricted your access to the patient's information.
2. By using UCI Health MyChart, you affirm your acceptance of UCI Health MyChart's Terms and Conditions and agree to comply with them now and throughout the period of your use of UCI Health MyChart. If you do not agree to the Terms and Conditions, do not proceed to use UCI Health MyChart.
3. Parents or guardians of children age 0-11 must complete the enrollment process in person. Birth or adoptive parents must present photo identification and sign this form acknowledging that they have a right to the child's health care information. If you are not the birth or adoptive parent of the child, you must present legal paperwork (such as a court order or medical power of attorney) proving you are the legally recognized caregiver for the child.
4. You agree that it is your responsibility to select a confidential password, to maintain your password in a secure manner, and to change your password if you believe it may have been compromised in any way.
5. You understand that UCI Health MyChart contains selected, limited medical information from a patient's medical record and that UCI Health MyChart does not reflect the complete contents of the medical record. You also understand that a paper copy of a patient's medical record may be requested from the UCI Health's Health Information Management Department.
6. You understand that your activities within UCI MyChart may be tracked by computer audit and that entries you make become part of the patient's legal medical record.
7. You understand that access to UCI Health MyChart is provided by UCI Health as a convenience to its patients and that UCI Health has the right to deactivate access to UCI Health MyChart at any time for any reason. You understand that use of UCI Health MyChart is voluntary and you are not required to use UCI Health MyChart or to authorize a MyChart proxy. UCI Health reserves the right to revoke online access to MyChart at any time.
8. By signing below, you acknowledge that you have read and understand this UCI Health MyChart Proxy form and you agree to its terms.

SECTION 3

_____ Date: _____ Time: _____ AM/PM
Proxy Signature (Parent/Guardian)

_____ _____
Printed Name of Proxy (Parent/Guardian) Relationship to Patient

If Interpreted: _____ _____ Date: _____ Time: _____ AM/PM
ID# Language

☐ Telephonic ☐ Video Interpreter

Clinic Use Only: Completed forms should be scanned into the patient's medical record and proxy access established once identity has been verified. Disregard scanning Page 3 if blank.

Patient Label

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SECTION 4

This section is an authorization that will permit UCI Health to release your health information to your designated proxy. Please read it carefully. This form should be completed by the patient who is authorizing another individual to access the health information in his or her MyUCIChart record. This form must only be completed by patients authorizing Enhanced Teen Proxy or Adult to Adult Proxy access.

I am requesting that _____
(insert name of proxy, *must match name in Section 1*)

receives access to my health information that is available in UCI Health MyChart. This person is my designated MyChart proxy. I authorize UCI Health MyChart to release the health information contained in my UCI Health MyChart record to my MyChart designated proxy. I understand that the medical information in my UCI Health MyChart account is obtained from my electronic health record. I authorize release of this information only through my UCI Health MyChart record. This form does not authorize release of my health record to my designated proxy by other methods or in other formats. I understand that once information has been disclosed, it potentially may be re-disclosed by the proxy and the disclosed information may not be covered by the same privacy protections.

Participating in UCI Health MyChart and designating a MyChart proxy are completely voluntary. I understand that I am not required to designate a MyChart proxy and I am not required to provide this authorization. I also understand that UCI Health MyChart does not condition any of my health care treatment, payment or other services on whether I provide this authorization. However, I also understand that if I do not provide authorization, UCI Health MyChart is not permitted to provide my designated proxy access to my UCI Health MyChart record.

This authorization will automatically expire five years from the date of my signature. I also may cancel this authorization at any time online within my UCI Health MyChart account or by providing a written request for cancellation to my primary clinic. I understand that if I cancel this authorization, my designated proxy's access to my UCI Health MyChart record will be ended. I also understand my cancellation will not affect any disclosures that were made prior to processing the revocation before my cancellation request is processed.

_____ Date: _____ Time: _____ AM/PM
Patient Signature

_____
Printed Name of Patient

_____ Date: _____ Time: _____ AM/PM
Proxy Signature (Parent/Guardian)

_____ _____
Printed Name of Proxy (Parent/Guardian) If Authorized Signature, Relationship to Patient

If Interpreted: _____ _____ Date: _____ Time: _____ AM/PM
ID# Language
☐ Telephonic ☐ Video Interpreter

Note: Authorization expires five years from the date of signature (above) unless child proxy reaches age 12 or upon implementing an authorized request to revoke proxy access. This release of medical information form must be submitted every five years to renew proxy access. You also may deactivate the access of the adult proxy specified above at any time through UCI Health MyChart or by providing a written request to your primary clinic.

Clinic Use Only: Completed forms should be scanned into the patient's medical record and proxy access established once identity has been verified. Disregard scanning Page 3 if blank.