UCSF Medical Center — MyChart Proxy Authorization Form
Granting Proxy Access to Parent/Guardian on behalf of a

CHILD (0-11 years)

CHILD'S NAME__________________________________ **CHILD'S BIRTHDATE**______________

CHILD'S MEDICAL RECORD #: _ _ _ _ _ _ _ _ _ ***(optional)*** **Last 4 of Social Security:** _ _ _ _ ***(optional)***

Important Reminder: UCSF MyChart displays certain information from your medical records, but **it does not display all health information** in your medical records.

Parent/Legal Guardian of Child: This authorization form is used for minors under the age of 12, in which, Attorney for Health Care, Advance Health Care Directive, or legal guardianship papers may be requested. A renewal of this authorization may be requested as well. Expiration of pediatric proxy access automatically occurs on the patient's 12th birthday.

AGREEMENT—
The *UCSF Medical Center (UCSFMC) Terms and Conditions for UCSF MyChart, and the UCSF MyChart Proxy/Disclaimer* for access to My Family's Record UCSF MyChart section control this agreement between the child's parent/legal guardian and UCSF Medical Center. Please refer to these documents when you signup online.

YOUR RIGHTS
This Authorization to release health information is voluntary. You may revoke proxy access at any time to your family member's UCSF MyChart account. For revocation, please contact your family member's practice. The Revocation will take effect within 2 business days upon notification of your request except to the extent UCSF Medical Center or others have already relied on it.

REVOCATION/EXPIRATION OF AUTHORIZATION
Unless otherwise revoked, or ended by revocation, authorization for UCSF MyChart proxy access will expire automatically when the patient turns 18 years old. In order for revocation to be effective, it must be executed in writing.

Print Name of Child's Parent/Legal Guardian:____

Relationship to Child: (parent/legal guardian): ____ Parent ____ Legal Guardian

Address: ________________________________ **Child's parent/legal guardian birthdate:** _______/________/________

________________________________ **Contact Phone Number:** (__ __ __) __ __ __ - __ __ __ __

Email Address: ____

☐ **Check** if the parent/guardian is a **UCSF patient**
MRN #: __ __ __ __ __ __ __ __ (optional) Last 4 of Social Security: __ __ __ __ (optional)

☐ **Check** if the parent/guardian is **NOT a UCSF patient**
Full Social Security #: _ _ _ - _ _ - _ _ _ _ (optional) Gender: Male ___ Female ___

Primary Language: ________________________ Marital Status:______________________________

Employer: ________________________________ (optional)

I attest that the above information is true and correct.

Signature of Child's Parent/Legal Guardian:

____ Date:__________________________________

Practice Representative who witnessed this proxy:

____ Date:__________________________________

A copy is as valid as the original

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ADMINISTRATION ONLY: ____ Scanned to Child's Record (Document Type UCSF Clinical Outpatient Documentation — 200122) - 11_07_2012