UCSF Benioff Children's Physicians

UBCP MyChart Proxy Authorization Form

Granting Proxy Access to Parent/Guardian on behalf of an

ADOLESCENT (12-17 years)

Tri-Valley Pediatrics, Inc.

PATIENT'S NAME_____ **PATIENT'S BIRTHDATE**_____

PATIENT'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. **To secure all health information, contact Health Information Management 415-476-9000**

Parent/Legal Guardian of Adolescent: This authorization form is used to establish UCSF MyCart accounts for both the Parent/Legal Guardian and the adolescent patient. This authorization form serves as acknowledgement and permission for my adolescent to have a UCSF MyChart account. Legal papers establishing parental or guardian relationship may be requested. A renewal of this authorization may be requested as well. Expiration of proxy access automatically occurs on the patient's 18th 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. For revocation, please contact the patient'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 not expire unless the relationship between the legal guardian and the patient changes.

Print Name of Parent/Legal Guardian:_____

Address: _____ **Patient'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 Patient's Parent/Legal Guardian:

_____ Date:_____

Practice Representative who witnessed this proxy:

_____ Date:_____

A copy is as valid as the original

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