Children's MINNESOTA

AUTHORIZATION FOR PROXY ACCESS TO MYCHILDREN'S PORTAL

1. INSTRUCTIONS	To grant proxy access to your MyChildren's Portal record, please complete this form and return to Children's Health Information Management Department in person, mail, or fax: **Health Information Management (HIM)** 2525 Chicago Avenue South Mail stop 32-B832 Minneapolis, MN 55404 Phone#: 612-813-6216 Fax#: 612-813-5849 Email: HIM@childrensmn.org **Health Information Management (HIM)** 345 North Smith Avenue Mail stop 70-102 St. Paul, MN 55102
2. PATIENT IDENTIFICATION	First Name: _____ Last Name: _____ Birth Date: _____ Address: _____ _____
3. PROXY IDENTIFICATION	First Name: _____ Last Name: _____ Birth Date: _____ Address: _____ Home Phone : ( ) _____ _____ Mobile Phone: ( ) _____ Relationship to Patient: _____ Email address: _____
4. PURPOSE OF ACCESS	Patient requests proxy access for assistance with his/her treatment or payment related activities.
5. INFORMATION AVAILABLE THROUGH MYCHILDREN'S ACCESS	I authorize release of protected health information obtained from my electronic medical record to Proxy through the MyChildren's Portal. The information in MyChildren's Portal includes medical, prescription, and financial information and may include substance abuse, reproductive health, mental health, HIV/AIDS, sexually transmitted infections, other infectious diseases, and genetic information.
6. UNDERSTANDING	• I understand this authorization will expire only upon my notice of revocation as instructed below. • I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so by contacting Health Information Management as indicated in section 1 above. I understand that stopping this authorization will not apply to information that has already been accessed or disclosed. • I understand MyChildren's Portal is intended as a secure online source of confidential medical information. If the user ID and password are shared with another person, that person may be able to view this information. • I understand once information has been disclosed, it potentially may be re-disclosed by the Proxy and may not be covered by federal privacy protections. • I understand MyChildren's Portal access is provided as a convenience and Children's Minnesota may deactivate access at any time for any reason. • I understand that signing this authorization is voluntary. I can refuse to sign this authorization and it will not affect my ability to obtain treatment.
7. DATE AND SIGNATURE	_____ _____ Signature of Patient/Authorized Person Date

* P O R T P R O X *

HIM USE ONLY

Initials: _____

Date: _____