



UBCP MyChart Proxy Authorization Form
Authorization for Parent/Legal Guardian to Disclose Health Information & Grant Proxy Access to Patient's (Age 0 - 11 Yrs Old) UBCP MyChart Account

PATIENT'S NAME: PATIENT'S DATE OF BIRTH:
PATIENT'S MEDICAL RECORD #: Last 4 of Patient Social Security #: \_ \_ \_ \_

Important Reminder: UBCP MyChart displays certain health information from 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 an Attorney for Health Care, Advance Health Care Directive, or legal papers establishing parental or legal guardianship may be requested. A renewal of this authorization may be requested as well. Expiration of proxy access automatically occurs on the patient's 12th birthday.

AGREEMENT

The UCSF Benioff Children's Physicians (UBCP) Terms and Conditions for UBCP MyChart, and the UBCP MyChart Proxy/Disclaimer for access to My Family's Record in the UBCP MyChart section control this agreement between the patient's Parent/Legal Guardian and UBCP. Please refer to these documents when you sign up 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 two (2) business days upon notification of your request except to the extent UBCP or others have already relied on it.

REVOCATION/EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, or ended by revocation, authorization for UBCP MyChart proxy access will expire automatically when the patient turns 12 years old. In order for revocation to be effective, it must be executed in writing.

Print Name of Parent/Legal Guardian:
If the Parent/Legal Guardian is an UBCP patient:
MRN:
Last 4 of Social Security #:
If the Parent/Legal Guardian is NOT an UBCP patient:
Full Social Security #: (optional)
Sex: Male Female
Date of Birth: (parent's date of birth)
Preferred Contact #:
Address:
Preferred Language:

I attest that the above information is true and correct.

Signature of Patient's Parent/Legal Guardian: Date:

Practice representative who witnessed this proxy:

(Print Name)
(Signature) Date: