Children's Mercy

Authorization for Proxy Access to MyChildrensMercy Patient Portal

8071-502 MR 02/23

MyChildrensMercy Terms and Conditions

Complete this form if you are a parent, legal guardian, adult or legally emancipated patient and wish to allow another person(s) to access the MyChildrensMercy Patient Portal (Patient Portal) account for the patient identified above. The person you designate is known as a Proxy or if you designate more than one person they are collectively Proxies.

I hereby authorize The Children's Mercy Hospital (CMH) to provide the individual(s) named below (the "Proxy" or "Proxies") access to the identified patient's health information through the Patient Portal. By signing below, I understand and agree to the following:

- I understand and acknowledge individuals who are granted proxy access are held to the terms stated in the Patient Portal Information Document.
- I understand this form is an authorization to grant the identified individual(s) proxy access to the patient's Patient Portal account. By signing this form, I authorize the designated Proxy to access all the patient's health information in the Patient Portal. I understand that this might include sensitive information such as test results, medications, diagnoses, information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, drugs alcohol and/or addiction.
  - I understand Proxy/ies will be granted the same type of access to the Patient Portal that I have.
  - I understand that granting a proxy/ies access the Patient Portal does not remove or impact my ability to access the Patient Portal for this patient, or to communicate with the patient's medical care team via the Patient Portal.
  - I understand that CMH reserves the right to not release the patient's health information on the Patient Portal to the extent permitted by law.
  - I confirm that I am legally authorized to grant proxy access to the patient's Patient Portal and will notify CMH if I am no longer legally authorized to do so.
  - I understand that this authorization is valid until I revoke it in writing with the CMH Health Information Management Department within Patient Portal at HIM Pool or until the patient turns 18. If I revoke this authorization, my designated Proxy's access to the Patient Portal will be terminated. I understand any revocation will not apply to information that has already been released to the Proxy/ies in response to this authorization.
  - I understand that the patient's treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this form.
  - I understand that I have the right to refuse to sign this authorization or to revoke it at any time.
  - I understand that patient health information used or disclosed pursuant to this authorization may be redisclosed by the Proxy/ies and its confidentiality may no longer be protected by federal or state law.
  - I understand that the initial invitation to create a Patient Portal account will be sent to the below email address(es), and that notifications will be sent to the same email address(es) to announce incoming communications on the Patient Portal.

First Proxy Information:

Printed Name of Proxy | **Date of Birth** | **Email address of Proxy**

Second Proxy Information *use additional page if more than two proxies:

Printed Name of Proxy | **Date of Birth** | **Email address of Proxy**

Signature of Individual Authorizing Proxy Access:

Printed Name | **Signature** | **Date**