MyHealth Proxy Access Request

❑ **Verbal Request**

Send completed requests to ANY of the following:
Metropolitan Pediatrics – Health Information Services
15455 NW Greenbrier Parkway, Suite 112
Beaverton, OR 97006

Online via DocuSign™ by visiting www.metropediatrics.com
Fax completed form to 503-466-1858
Email completed form to HIS@metropediatrics.com

Patient Name: _____ Date of Birth: _____/_____/_____ Phone: _____

MyHealth Proxy

This section should be completed by the individual requesting access to the patient's chart.

Proxy Name: _____ Date of Birth: _____/_____/_____ Phone: _____

Address: _____
Street City State Zip Code

Social Security Number: _____ Email: _____

Relationship to Patient: ❑ Parent ❑ Legal Guardian ❑ Healthcare Representative ❑ Foster Parent ❑ Other: _____

MyHealth Agreement

A "proxy" is a person who has been given permission to access the patient's MyHealth account and medical information available within MyHealth. Proxy Access Requested (select one):

- ❑ Full proxy access to the account of a child 13 or younger (access automatically revoked on patient's 14th birthday)
- ❑ Full proxy access to the account of a teen 14-17 years old (access automatically revoked on patient's 18th birthday)
- ❑ Limited proxy access to the account of a teen 14-17 years old
- ❑ Limited proxy access to the account of a foster child (access must be approved by DHS)
- ❑ Full proxy access to the account of an adult (access remains until revoked)

Proxies other than the parent must provide documentation that establishes they are the patient's legal guardian or healthcare representative. If guardianship and/or foster status changes, it is the responsibility of the proxy to notify us immediately.

I understand that: (1) MyHealth may contain limited medical information and may not reflect the complete contents of the medical record; (2) My activities within MyHealth may become part of the above-named patient's medical record; (3) By providing access to a proxy, any information maintained in the above-named patient's record may be available to the listed proxy unless I expressly request to my provider at the time of service that it not be shared. This may include, but is not limited to, information related to HIV test results and/or diagnosis; other sexually transmitted diseases; mental health diagnosis or treatment information; genetic testing information; and drug/alcohol diagnosis, treatment, or referral information; (4) I may revoke this authorization at any time via the MyHealth portal or by contacting Metropolitan Pediatrics directly; and (5) My agreement will not affect my ability to obtain healthcare services or reimbursement for services.

X_____ _____ X_____/_____/_____
Signature of Proxy (or Employee if verbal request) Print Name Date

X_____ _____ X_____/_____/_____
Signature of Patient REQUIRED if Age 14+ Print Name Date

INTERNAL USE ONLY

Proxy Type: ❑ Parent Accessing Child ❑ Limited Access ❑ Diminished Capacity ❑ Foster Parent Access (activated by FYCC only)

Activated On: _____/_____/_____ By: _____
🗁 HIS: Scan into media tab once complete.

Rev. 04/23/2021