UCSF Benioff Children's Physicians

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 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 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 # : _ _ _ - _ _ - _ _ _ _

Sex: Male ☐ Female ☐

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:**____/____/_____

A copy is as valid as the original.