West Texas Developmental Pediatric
& Behavioral Health Network, P.A.

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

MyTeamCare Patient Portal
Proxy Access to Adolescent Patient (age 13-17)

I, as parent/legal guardian, am requesting to participate in UMC Health System's Patient Portal as proxy to my adolescent child/children.

Proxy Name: _____ Date of Birth: _____

Relationship to child/children: _____

Email Address (case sensitive): _____
(please supply the email address of the person who will be using the patient portal)

Phone Number: _____
(Once your information has been entered and proxy granted, you will receive an email with a one-time user/password with instructions to create your own unique password to access MyTeamCare.)

- I understand that my Proxy will have the same access and privileges that I have for the patient portal.
- I understand that this allows my Proxy online access to my personal health information. My Proxy will be able to view portions of my record that I am able to view, which may include information relating to sexually transmitted disease, birth control or family planning, tuberculosis (TB), hepatitis B, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), genetic information behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand that West Texas Behavioral Health and UMC Health System cannot condition treatment of payment for services rendered on my signing of this authorization.
- I understand that additional information may be made available to my Proxy through the patient portal as UMC Health System continues to implement this product.
- I understand that West Texas Behavioral Health and UMC Health System is not responsible for the Proxy's inappropriate use of publication of the information they gain access to through the patient portal.
- This authorization is valid until revoked by me. I understand that a written request is necessary to revoke or cancel this authorization.
- I understand that revocation will not be effective as to uses and/or disclosures already made in reliance upon this authorization.
- I realize that the information used and/or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by privacy laws.

By signing this authorization, I am requesting West Texas Behavioral Health and UMC Health System to give access to my Proxy to utilize the patient portal.

_____ _____
Signature of Adolescent Date Time

_____ _____
Signature of Parent of Legal Guardian Date Time

West Texas Developmental Pediatric & Behavioral Health Network, P.A.

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

MyTeamCare Patient Portal
Permission for Adolescent Access (age 13-17)

Purpose for the Access: To allow my child between the ages of 13 and 17 to view and communicate regarding their own health information through *MyTeamCare* for treatment purposes.

I, authorize West Texas Behavioral Health and UMC Health System, to release information via MyTeamCare Patient Portal to:

Adolescent's Name _____ Adolescent's Email Address _____

The following information will be released: Any and all information as available through MyTeamCare.

- I understand that I have a right to revoke this permission at any time by completing the Proxy Revocation Form or by contacting MyTeamCare at 877-621-8014. If permission is revoked, portal access will be terminated until the patient reaches the age of 18.
- I understand that this authorization is in effect until it is revoked.
- I understand that any revocation will not apply to information that has already been released in response to this authorization.
- I understand that the health information in MyTeamCare may include information relating to relating sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), birth control or family planning, tuberculosis (TB), hepatitis B, genetic information behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand that I can refuse to sign this form and treatment will not be affected.
- If I have questions about HIPAA and my rights related to the disclosure of my child's health information, I may contact the West Texas Behavioral Health Compliance/Privacy Officer.
- I agree to waive and release my physician, West Texas Behavioral Health, UMCHS, and its affiliated entities, and its officers, directors, employees, agents, successors, and assigns from any and all claims or causes of action that in any way relate to the of MyTeamCare by my child.
- I understand that the health information available online through MyTeamCare is NOT an official or complete copy of my child's entire medical record. I understand I may request a copy of the official medical record and that there may be search, handling, and photocopying fees associated with obtaining an official copy of the medical records.
- I understand it is the policy of West Texas Behavioral Health and UMCHS to not give parents or legal guardians access to an adolescent's MyTeamCare account but I may contact my child's physician or nurse to discuss their healthcare and treatment.

I have read (or had read to me) this document and the Information Sheet and all my questions have been answered. I agree to the use and disclosure of the information described.

Signature of Patient or Legal Representative _____ Date _____ Time _____