



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

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

MyTeamCare Patient Portal Proxy Access to Adult Patient (18 and older)

I authorized the following individual to participate in MyTeamCare Patient Portal as my Proxy.

Proxy Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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.
I understand the portal is not the legal medical record and I still have the right to request a copy of my medical record as outlined in the HIPAA Privacy Policies.

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 Patient of Legal Representative

Date Time

Signature of Proxy

Date Time