PATIENT PORTAL PROXY - Minor (under age twelve)

A proxy is able to access the patient's protected health information maintained within the *FollowMyHealth* portal.

The State of Wisconsin restricts access to health information for minors between the ages of 12-17, as a result, we cannot grant access to this protected age group. Please visit our web page at http://www.uhsi.org/Patients-Visitors/Patient-Portal-FAQ/ for information regarding minor proxy accounts.

Fill out one form per child.

Parent/Guardian Information:

First Name, Middle Initial and Last Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: ____/____/_____ Phone Number: (____)_____

E-Mail Address: _____

Patient Information:

First Name, Middle Initial and Last Name: _____

Date of Birth: ____/____/_____ Age: _____

Medical Record Number: _____
(to be filled out by Health Care Staff)

Relationship:

☐ Parent

☐ Court Appointed Legal Guardian - Proxy must attach a copy of the Court Order Appointing Guardian and Letters of Guardianship verifying the proxy's status as permanent legal guardian.

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UNITED HOSPITAL SYSTEM

Proxy Request Form

I acknowledge and agree to the following:

1. I must present my photo ID for identity verification.
2. I will comply with the Terms of Service on the *FollowMyHealth* website.
3. My access to the patient's *FollowMyHealth* health information will end on the date that the child turns 12.
4. If I am the legal guardian, I have the proper documentation authorizing me as a legal representative for the patient, thereby allowing me access to his/her health information within the *FollowMyHealth* portal.
5. If I am the legal guardian, when my legal authority to act on behalf of the patient has been inactivated, revoked, terminated or expired; I must immediately notify United Hospital System of the revocation, termination or expiration. If written, this notification must be dropped off at or sent to **Health Information Management Department, United Hospital System, 6308 8th Avenue, Kenosha, WI 53143**. I may also opt to call in my notification at 262-656-2283.
6. I understand that *FollowMyHealth* contains selected, limited medical information from the patient's medical record and that the *FollowMyHealth* portal does not reflect the complete contents of the medical record. I also understand that a paper copy of the patient's medical record may be requested from the United Hospital System Medical Records Department at the address listed above.
7. I understand that access to *FollowMyHealth* is provided by United Hospital System as a convenience to its patients and United Hospital System has the right to deactivate access to *FollowMyHealth* at any time for any reason.

By signing below, I acknowledge that I have read and understand the information listed above and I agree to these terms.

Proxy Signature:_____ Date:_____

FOR OFFICE USE:

I have verified or completed the following:

1. The authorization form has been properly completed.
2. The relationship box has been checked.
3. The authorized representative has documentation on file proving their authority to sign for the patient.
4. I have viewed the photo ID to confirm the identity of the parent or authorized representative requesting proxy access.
5. Minor proxy is under age twelve.

Form has been sent to DL_Follow_My_Health Yes / No

Print Name:_____ Title: _____

Signature:_____ Date / Time:_____

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