FOR PATIENTS 12 AND OLDER

MyHealth Online Access Authorization Form

I am a patient of The University of Vermont Medical Center. I authorize the UVM Medical Center to grant full access to my MyHealth Online account to the person(s) identified below as "proxy."

- I understand that I have the right to revoke this authorization at any time.
- I understand that the information available to this person through my MyHealth Online account may include information related to sexually transmitted diseases, treatment for alcohol or drug abuse, and treatment for behavioral or mental health conditions.
- I understand that this person is not bound by the state and federal laws that protect the privacy and confidentiality of the health information recorded in the MyHealth Online account.
- I understand that signing this form is voluntary. I can refuse to sign this authorization.
- I understand that if I refuse to sign this authorization, it will not affect my ability to receive medical care or services at the UVM Medical Center.
- I understand that the UVM Medical Center reserves the right to terminate access to any MyHealth Online account for any reason.

PATIENT:

Name: ____

Date of Birth: ______________________ Email address: ______________________

Signature: ______________________ Date & Time: ______________________

PROXY 1: THIS PERSON WILL BE GRANTED ACCESS TO THE PATIENT'S MYHEALTH ONLINE ACCOUNT*.

Name: ____

Date of Birth: ______________ Address: ______________________

Phone: ______________ Email address: ______________________

Does proxy have a medical record number (MRN)? Yes _______ No _______

(If not, a UVM Medical Center MRN will be assigned before proxy access can be granted.)

Form continues on other side

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THE University of Vermont MEDICAL CENTER

PROXY 2: THIS PERSON WILL BE GRANTED ACCESS TO THE PATIENT'S MYHEALTH ONLINE ACCOUNT*.

Name: ______________________________ Date of Birth: ____________

Does proxy have an MRN? Yes _____ No _____

(If not, a UVM Medical Center MRN will be assigned before proxy access can be granted.)

Address: ____

Phone: __________________ Email address: ______________________

**If you are not the legal guardian of a patient who is under 18 years old, consent from the patient's legal guardian must be provided in the space below in order for you to be granted proxy access.*

CONSENT FROM PATIENT'S PARENT OR LEGAL GUARDIAN TO SET UP PROXY ACCESS

Name: ____

Date of Birth: __________________

Address: ____

Phone: __________________ Email address: ______________________

Signature: ____

Date & Time: ____

FOR MORE INFORMATION

To find health information, or for convenient and secure access to your medical record through MyHealth Online, visit **UVMHealth.org** or call us at **(802) 847-7500** or **(888) 979-1414.**

Bring the completed form to the UVM Medical Center clinic where the patient receives care.

If you cannot go to a clinic, you may send the signed form to:

UVM Medical Center
HIM - Holly Court
111 Colchester Avenue
Burlington, VT 05401

UVMHealth.org/MedCenter