

MyHealth Online Proxy Access Authorization Form

I am a parent or guardian of a patient of The University of Vermont Medical Center who is under 12 years old. I authorize the UVM Medical Center to grant me full proxy access to the patient's MyHealth Online account. I understand that, when the patient turns 12 years old, my proxy access will be automatically terminated.

PATIENT:

Name: _____

Date of Birth: _____ Address: _____

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

Name: _____

Date of Birth: _____ Address: _____

Phone: _____ Email address: _____

I have read and understand the requirements and procedures for accessing my child's medical record online as described in the "What is MyHealth Online Proxy Access?" information sheet. I certify that I am the parent or legal guardian of the child listed above, and all the information I have provided is correct. I hereby request access to my child's medical record online, through the MyHealth Online portal.

Signature: _____ Date & Time: _____

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.)

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

Name: _____

Date of Birth: _____ Phone: _____

Address: _____

Email address: _____

I have read and understand the requirements and procedures for accessing my child's medical record online as described in the "What is MyHealth Online Proxy Access?" information sheet. I certify that I am the parent or legal guardian of the child listed above, and all the information I have provided is correct. I hereby request access to my child's medical record online, through the MyHealth Online portal.

Signature: _____

Does proxy have an MRN? Yes _____ No _____

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

**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 obtained 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

