# University of Pittsburgh Medical Center (UPMC)

## Pediatric Proxy Request Form

**What is Proxy?**

MyUPMC includes a Proxy access feature, where on behalf of the patient, designated family members or other authorized individuals are granted access to the patient's select health information through MyUPMC.

**Dear Parent/Legal Guardian:**

*We understand you wish to obtain proxy access to MyUPMC on your child's behalf. In regards to this matter, privacy of your child's health care information is important to us. In the spaces below, provide the requested information about your child (the patient) and the person you are assigning to act as their proxy.*

*By obtaining proxy access, you will be able to access features of MyUPMC that will vary depending on the age of the child.*

***Note this form is not applicable and cannot be used for UPMC behavioral health patients or for any patient when health care decisions are involved**, including, but not limited to: (1) procedures/services that require informed consent (and withdrawal of consent if applicable), (2) admissions to and discharges from nursing homes or other long-term care facilities, (3) donation of organs, body parts, or body for medical purposes, including the authorization of an autopsy, and (4) continuation or withdrawal of life support. For major health care decisions, a formal power of attorney or living will is recommended.*

## MyUPMC Proxy Terms and Agreement

*Please note: The MyUPMC Proxy Terms and Agreement are subject to change.
At any time, you may review the most up-to-date terms and agreement online at MyUPMC.com

1. I understand that MyUPMC is not is not a tool to be used in the case of a medical emergency or urgent situation. If an emergency or urgent situation arises, I will seek appropriate emergency medical service.

2. I understand that MyUPMC is intended as a secure online source of certain confidential medical and billing information. If I share my MyUPMC username and password with another person, that person may be able to view health information about me or the patient.

3. I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.

4. I understand that MyUPMC contains *select* medical information from a patient's medical record and that MyUPMC is a tool of convenience and does not substitute or reflect the complete contents of the patient's medical record. I further understand that MyUPMC contains information from UPMC physician offices that use UPMC's electronic health record system, and that the proxy will be able to access information from all of those physician offices. Such information may include information associated with HIV, mental health, drug and alcohol treatment.

5. I understand that in lieu of, or in addition to, select information contained in MyUPMC, I may access any and all of that patient's medical records that I am lawfully entitled to by contacting the appropriate UPMC facility's medical records department and requesting medical records in accordance to UPMC policy.

6. I understand that by obtaining proxy access, I will be permitted to do the following:
    - request appointments for healthcare services with UPMC health care providers that participate in MyUPMC
    - view select medical information that is available within MyUPMC
    - request certain online medical services from UPMC AnywhereCare
    - communicate via MyUPMC, by phone or in person with the patient's UPMC health care providers on MyUPMC regarding tests, treatments, medications, patient advice and administrative tasks
    - communicate via MyUPMC with CCP's billing office regarding any of the patient's UPMC bills

7. I understand as a proxy I will be able to request certain online medical services from UPMC AnywhereCare, on the child's behalf. I accept financial liability for such service that includes applicable charges if the child's insurance does not cover all or part of this service.

8. I understand all activities within MyUPMC will be tracked by computer audit and that entries will become a permanent part of the medical record.

9. I understand that access to MyUPMC is provided by UPMC as a convenience to our patients and that UPMC has the right to deactivate proxy access to the MyUPMC account or that of the proxy at any time for any reason, including cases where UPMC reasonably believes that it is not in your best interest to continue to provide MyUPMC access to you as proxy.

10. Pediatric proxy access is a convenience tool provided at the sole discretion of UPMC. I understand that at age 13, access to a child's health record using MyUPMC will be limited or may be discontinued for privacy reasons. I acknowledge and agree that I am not entitled to an explanation of the reason for discontinuation.

11. I understand that Pediatric Proxy access will automatically discontinue when the child turns age 18. At that time the child may request their own account, or as the parent/legal guardian I can request Adult Proxy access.

12. I will not use MyUPMC proxy access for *frivolous purposes or for purposes* unrelated to the care or treatment of the patient.

13. I understand the use of proxy access is for the care of the MyUPMC member. If I no longer need to have proxy access, I should notify UPMC immediately.

14. I am entitled to a copy of this completed form.

By signing below, I acknowledge that I have read and understand this MyUPMC Pediatric Proxy Request form and I agree to its terms.

- _____/_____/_____
  **Signature of Proxy** *(Required)* ****Relationship to Patient** **Date**

- _____
  **Print name of provider or practice** (*Required)*

****Pediatric Proxy will only be granted to biological parents and legal guardians. If you are a legal guardian, you will be required to submit supporting documentation before pediatric proxy access is granted.**

***To obtain proxy access please complete the below request form.***

Return this form to: ***(*Please return only this page)*** or Fax: 724-933-1105
Children's Community Pediatrics
11279 Perry Highway, Suite 450
Wexford, PA 15090

Proxy's Information (All sections required -- please print clearly.)

Name *(last, first, middle initial)*:_____

Gender - *Please Circle*: Female or Male

Date of Birth: _____

Home Address: _____

City:_____ State:_____ Zip:_____

Home Phone Number: _____Cell Phone Number (*optional*): _____

E-mail Address: _____

Relationship to Patient: _____

Child's Information (Please verify that the information below is correct. Notify office of incorrect information.)

Name *(last, first, middle initial)*:_____

Gender - *Please Circle*: Female or Male

Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone Number(s): _____