COPA

CENTRAL OREGON
PEDIATRIC ASSOCIATES

MyHealth Proxy Access Request

Send MyHealth Proxy Access Requests / Revocation Requests to ⇨ COPA – Medical Records Department:
2200 NE Professional Court • Bend, OR 97701 • 541-389-6313 • F 541-389-8760

Patient Name: _____ Date of Birth: _____/_____/_____ Phone: (_____) _____

Address: _____
Street City State Zip Code

Do we have permission to leave a voicemail if we have questions about setting up access? ❑ Yes ❑ No

MyHealth Proxy

This section should be completed by the individual requesting access to the patient's chart.

Proxy Name: _____ Date of Birth: _____/_____/_____ Phone: (_____) _____

Address: _____
Street City State Zip Code

*Social Security Number: _____-_____-_____ Email: _____

**if you do not wish to use a social security number, leave this section blank and you will be issued an access code of 0000.*

MyHealth Agreement

A ***proxy*** is a person who has been given permission to access the patient's MyHealth account and medical information available within MyHealth. Proxy access is available to the following:

- ⇨ Anyone an adult patient permits to be a proxy (spouse)
- ⇨ Parent of a minor (birth parent or adoptive parent)
- ⇨ Legal guardian of a minor or adult
- ⇨ Parent/legal guardian of a developmentally disabled minor or adult patient

If you are not the birth or adoptive parent (e.g., stepparent, grandparent), you must provide documentation that establishes that you are the patient's legal guardian/healthcare representative.

I understand that MyHealth may contain limited medical information and may not reflect the complete contents of the medical record.

I understand that Central Oregon Pediatric Associates has the right to deactivate access to MyHealth at any time for any reason.

I understand that my activities within MyHealth may become part of the above-named patient's medical record.

I authorize the disclosure of any information maintained in my MyHealth record as it may pertain to me, including information related to: HIV test results and HIV diagnosis, other sexually transmitted diseases, mental health diagnosis or treatment information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

Federal and/or state law may restrict re-disclosure of protected health information. I understand that once information has been disclosed, it potentially may be re-disclosed by the proxy and privacy laws may no longer protect my information.

My refusal to sign this authorization will not affect my ability to obtain healthcare services or reimbursement for services.

I understand that I may revoke this authorization by submitting a written request for revocation to COPAs' Medical Record Department.

X_____ _____ X_____/_____/_____
Signature of Proxy | Print Name | Relationship | Date

X_____ _____ X_____/_____/_____
Signature of Patient 14+ Years – REQUIRED | Print Name | Date

INTERNAL USE ONLY

Mark the type of MyHealth proxy access:

- ❑ Adult accessing adult patient record
  - ⇨ Access will remain in effect until revoked.
- ❑ Parent or legal guardian accessing minor patient record
  - ⇨ Patients under 13 years old: Proxy access will expire on the patient's 14th birthday.
  - ⇨ Patients 14 to 17 years old: Proxy access will expire on the patient's 18th birthday.
- ❑ Parent or legal guardian accessing developmentally disabled minor or adult patient record

I have verified:

- ❑ Form is complete
- ❑ Proxy activated: _____/_____/_____

Employee: