UnionHealth™
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www.union.health

MRN:

PATIENT PORTAL CONSENT TO ACCESS

This Union Health Patient Portal Consent to Access allows you to request portal access to your medical records for yourself and/or by a designated individual (your "Proxy"). Please fill this form out as completely as possible. If you are a proxy requesting access on behalf of the patient you must either present with the patient, with a valid photo identification, social security card, birth certificate, or other acceptable proof of relationship to the patient.

Patient Information

Last Name	First Name	Middle	Date of birth

Street Address	City	State	Zip Code

Phone Number	Email

By entering an email address above, you consent to receiving communications from Union Health by email. Please note that Union Health cannot guarantee the security of an email transmission. You acknowledge and agree that email is not a secure form of communication and that there is risk an unauthorized party may intercept your communication.

Proxy Information

PLEASE COMPLETE THE BOX BELOW CONTAINING THE TYPE OF PROXY ACCESS REQUESTED

Applicable supporting documentation of the guardianship must be provided with this request.

ADULT PATIENT OR EMANCIPATED MINOR*

***check all that apply.**

- ☐ **Patient is requesting access for him/herself**
- ☐ **Access is requested for Patient Proxy**

Relationship of Proxy to adult patient or emancipated minor is:

- ☐ **Other Adult:**
  The patient must sign this form to provide authorization for the release of their medical information via the Union Health Patient Portal.
- ☐ **Legal Representative of Adult Patient:**
  Select the option below that currently describes this relationship:
  - ☐ **Power of Attorney for Health Care**
  - ☐ **Legal Guardian (court order)**
  - ☐ **Other:**

MINOR PATIENT (age 0-13)

Proxy's relationship to the minor patient between the ages of 0 and 13

Individuals requesting this access must have parental rights that are not limited by court order or legal guardianship granted by court order:

- ☐ **Parent**
- ☐ **Permanent Legal Guardian**

Access expires when the patient reaches the age of 14.

MINOR PATIENT (age 14-17)

- ☐ **Access is requested for adolescent patient only.**
- ☐ **Access for adolescent and Proxy is requested.**

Proxy's relationship to patient 14 to 17 yrs old:

- ☐ **Parent**
- ☐ **Permanent Legal Guardian**

Both the minor ages 14-17 and the Proxy must sign this consent form in person during the registration process.

Proxy Information

Last Name	First Name	Middle	Date of birth

Street Address	City	State	Zip Code

Phone Number	Email

Patient Authorization for Consent of Proxy

I understand and agree that:

1. I choose to designate the person named above as my Proxy to access my protected health information by way of Union Health's Patient Portal. I authorize release of any information contained in my Union Health Patient Portal to my Proxy. I understand this may include sensitive records, like communicable diseases, mental health, drug and alcohol, or other sensitive health information.
2. I understand that the medical information in the Union Health Patient Portal is obtained from my electronic medical record, but it may not represent all information Union Health has about the patient. If I need access to the full patient record, I understand that I may reach out to the Medical Records Department for assistance.
3. I understand that if I no longer want the Proxy named above to have access to my Union Health Patient Portal, I may revoke the Proxy's access by contacting the patient's primary care physician, in-person at patient registration, and/or by completing and submitting a Union Health Patient Portal Revocation of Proxy Access.
4. I understand that I am responsible for ensuring that the information set forth above, including, without limitation, the email address and other information, is accurate and complete.
5. As applicable, I agree to notify Union Health immediately in the event of a change of my Proxy's authority.
6. I agree to return this form to the patient's physician's office or the hospital to be placed in the patient's medical record.
7. I will comply with the terms and conditions of the My Union Health Portal, as posted at **www.myunionhealth.org.**

SIGNATURE OF PATIENT OR AUTHORIZED PERSON

EMANCIPATED MINORS SIGN HERE*

PATIENT SIGNATURE NOT REQUIRED WHEN PATIENT IS UNDER 14 OR WHEN A PROXY HAS LEGAL AUTHORITY

Patient Signature	Date

MINOR PATIENT AND AUTHORIZED PERSON

PATIENT AND PARENT SIGNATURE REQUIRED IF A PATIENT IS BETWEEN 14-17 YEARS OF AGE

Patient Signature	Date

Legal Guardian Signature	Date