Medical Record #_____
Proxy Photo ID Verified:_____
Legal Guardianship Verified: _____

Patient "Child" Information

Full Name_____ Date of Birth _____

Email Address_____ Social Security Number: XXX-XX-_____(last 4 digits)

Address _____

Day Phone #_____ Cell # _____ City State Zip

Proxy Information

Full Name_____ Date of Birth _____

Email Address_____ Social Security Number: XXX-XX-_____(last 4 digits)

Relationship to Patient _____ I have my own personal MyBCH Health Services account: ☐ Yes ☐ No

Address _____

Day Phone #_____ Cell # _____ City State Zip

Proxy Access Type Requested

☐ Medical Records ☐ Billing Information ☐ Both

Acknowledgement

- I understand that legal documentation (e.g. Guardianship or Legal Personal Representative) **may** be required. I must have parental rights or legal guardianship rights to access this child's record.
- I acknowledge that I have not been denied periods of physical placement with the child and there are no court orders or restraining orders in effect limiting my access to this child's medical records and/or information.
- I acknowledge that there are age range limitations for MyBCH Health Services Patient Portal. These age range limitations do not affect any legal right I have to access the child's record by other means. I can request a paper copy of the child's record by contacting the Medical Records Department.
- I understand that for a child age 0 to 11 years, I will be granted full access to the child's MyBCH Health Services Patient Portal, and on the child's 12th birthday, I will no longer have access to the child's MyBCH Health Services Patient Portal.
- I understand by submitting this form I, as the parent or legal guardian, have requested proxy access to the above-named patients information that resides in the electronic health record portal (MyBCH Health Services Patient Portal).
- I understand that the child's medical information is confidential. It is securely maintained in an electronic system by Boulder Community Health.
- I understand that failure to comply with the MyBCH Health Services Patient Portal User Agreement may result in the termination of portal access privileges.
- I understand that the child's MyBCH Health Services Patient Portal **may** include a diagnosis or reference to the following condition(s): *behavioral health services/psychiatric care; sickle cell anemia; genetic testing; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); or drug and/or alcohol abuse.*
- I acknowledge if I cease to be responsible for the health care decisions of the child, I will notify Boulder Community Health immediately.
- I understand that Boulder Community Health reserves the right to revoke access to the MyBCH Health Services Patient Portal at any time for any reason.
- I acknowledge that I have read and understand this Child Proxy Access: 0-11 form and that the full MyBCH Health Services Patient Portal User Agreement is available to me online.
- I understand that this authorization for my access to the child's MyBCH Health Services Patient Portal account will automatically expire if the Medical Records Department receives notice and documentation that I am no longer the child's guardian, if Boulder Community Health receives notice and documentation that there is a court order or restraining order in effect that would limit my access to the child's medical records and/or information, when the child's MyBCH Health Services Patient Portal account is deactivated, or when I revoke this authorization, whichever occurs first.
- ***A signature is required to validate this request. By signing this form, the signer is certifying they are the parent or legal guardian of the child listed above and that all information provided is correct. The signer is requesting access to electronically view the patient's medical record via the MyBCH Health Services Patient Portal.***

_____
Signature and PRINTED Name of Parent/Guardian Date

Submit Completed Form To

For questions or to present forms with identification in person:

Boulder Community Health Medical Records Department
4990 Pearl East Circle, Suite 100, Boulder. 303-415-7760.

Request for Child Proxy Access: 0-11

PATIENT INFORMATION

Place label here.