Medical Record #_____
ROI # _____

Proxy Photo ID Verified:_____
Legal Guardianship Verified: _____

Patient Information

Full Name_____Date of Birth _____
Email Address_____ Social Security Number: XXX-XX-_____(last 4 digits)
Address _____
City State Zip
Day Phone #_____Cell # _____

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 _____
City State Zip
Day Phone #_____Cell # _____

Proxy Access Type Requested

☐ Medical Records ☐ Billing Information ☐ Both

Acknowledgement

- I understand by submitting this form, I have requested the person indicated above to act on my behalf (a "proxy") to obtain information regarding my health included in my electronic health record.
- I understand that my 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 patient's MyBCH Health Services **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 understand that information accessed may be subject to redisclosure by the Proxy and is no longer protected by the HIPAA Privacy rule.
- I understand that if access to the patient's MyBCH Health Services Patient Portal is granted, access will remain in effect until revoked in writing.
- I understand that if access to MyBCH Health Services Patient Portal is revoked, the information previously viewed by the above-named person(s) would not be considered a breach of confidentiality.
- 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 Minor (12-17) Proxy Access form and that the full Terms and Conditions of the MyBCH Health Services Patient Portal are available to me online. I agree to its terms and choose to designate the person named above as my Patient Portal Proxy, thereby allowing them access to my Portal account.
- I understand that proxy access will be terminated on the patient's 18th birthday and that future portal access by proxy will have to be reestablished by completing a new proxy access authorization.

A signature is required to validate this request. By signing this form, the signer is requesting that the person(s) named above be granted access to electronically view the patient's medical record via the MyBCH Health Services

_____
Signature and PRINTED Name of Patient 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 MINOR (12-17) Proxy Access

Boulder Community Health

PATIENT INFORMATION

Place label here.