LEGACY HEALTH

Request to Access Another Patient's MyHealth Record

Patient Information

Patient Last Name	Patient First Name	Middle Name
Nickname/Maiden/Other Name		Birth Date
Patient Address		Telephone#

Request Type	Additional Required Documentation
1. ☐ Your minor child (age 13 or younger)	
2. ☐ Your minor child (age 14 to 18)	***Authorization to Use and Disclose Protected Health Information*** form signed by your child (the patient)
3. ☐ An adult	***Authorization to Use and Disclose Protected Health Information*** form signed by patient
4. ☐ A parent or an adult you care for (an individual for whom you are a legal caregiver or personal representative)	A copy of legal documentation showing your authority as the personal representative (i.e. legal guardian, health care representative, or durable power of attorney for healthcare). **You agree to inform the patient's clinic immediately if your legal relationship with the individual changes.**

Person Requesting Access

Last Name	First Name	Date of Birth:	
Address:	Email Address:	Telephone#	
Signature	Social Security Number	Relationship to Patient	Date
Primary Care Provider	Location of Primary Care Provider		

For Legacy Use Only

☐ Reviewed and verified form _____ initials
☐ Reviewed and verified Authorization Form for request types 2 and 3 _____ initials
☐ Legal Representative's Documentation received and verified for request type 4 _____ initials
☐ Proxy activated in Epic _____ initials
Scan forms into Epic.