**AUTHORIZATION (WITH PROXY MINOR)**
**ACCESS TO ON LINE HEALTH INFORMATION VIA MYTHEDACARE.ORG**

Patient Name: _____ Date of Birth: _____
(If Patient is a Minor Child, please complete Parent/Legal Guardian Proxy Information)

Patient Address: _____ Social Security Number: _____
(SSN used only to validate during access)

City/State/Zip: _____

I understand that access to MyThedaCare (on line record) is for access to only my personal health information or information regarding my minor child. **I understand that MyThedaCare is NOT to be used in an emergency.**

I understand that sharing my password or proxy (proxy is for minor child) with anyone else allows them access to personal health information, that they could add comments to the medical record, or send messages to the provider. I understand it is my responsibility to maintain my password in a secure manner and to change it if I feel it has been compromised in any way.

I understand that I am accessing the following information about myself or my minor child:

- Basic Laboratory Results
- Communication between my provider and myself
- Ability to review, request, or schedule appointments
- Request renewals of prescriptions
- Summary information about my medical history

The reason for this disclosure is to play a more active role in my own health care or the health care of my minor child. I understand that additional information may be made available to me through the MyThedaCare product, as ThedaCare advances this product.

I understand that my activities within MyThedaCare are tracked by computer audit and that entries I make can become part of my medical record or my minor child's medical record.

I understand that by signing this agreement I am providing ThedaCare documentation of my authorization to access my own protected health information as described above. Or, if patient is my minor child, I authorize that I am a proxy to my minor child's information as this child's parent or legal guardian. I understand that written request must be made to cancel or revoke this authorization and that any actions taken or accesses prior to that cancellation were authorized as part of the initial signature and date.

I understand that MyThedaCare is optional/voluntary and that my provider has the right to deactivate access to MyThedaCare for unauthorized or inappropriate actions on my part.

By signing below I am acknowledging that I understand the disclosure of my protected health information. Or, if authorization is for my minor child's health information by me for my use, I certify that I am the parent or legal guardian for the patient named above and that the information I have provided is correct.

Signature_____ Signature Date: _____

Print Name: _____ Relationship to Minor Child: _____
Relationship MUST be complete if acting as proxy

DOB_____