CAVALIER COUNTY MEMORIAL HOSPITAL & CLINICS
LANGDON, ND 58249

MyHealth Pediatric (age 0-17) Proxy Access Form

This form is to be completed in the clinic and left with office staff.

Access to my child/children's (age 0 – 17) MyHealth Record (*please print*)

Name of Child #1: _____ **DOB:** ___/___/___

Name of Child #2: _____ **DOB:** ___/___/___

Name of Child #3: _____ **DOB:** ___/___/___

Name of Child #4: _____ **DOB:** ___/___/___

Please note that your childs' chart will be accessed through your (the proxy's) MyHealth record. Completing this form will establish a MyHealth record for you (if you don't have one) and proxy access to your child's chart.

Authority of Proxy:

___ Patient is a minor and I am the patient's parent and natural guardian. My rights to seek medical information on the minor patient have not been limited by court order.
___ Patient is a minor and I am the patient's guardian.
___ Other: _____

MyHealth terms and conditions

- I understand that MyHealth is intended as a secure online source of confidential medical information. If I share my MyHealth ID and password with another person, that person may be able to view my or my child's health information, and health information about someone who has authorized me as a MyHealth proxy.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.
- I understand that MyHealth contains selected, limited medical information from a patient's medical record and that MyHealth does not reflect the complete contents of the medical record. MyHealth does not include medical information relating to diagnosis of mental illness, alcohol/drug abuse, sexually transmitted diseases, HIV, some communicable diseases, or pregnancy and childbirth. MyHealth does not include physician notes. MyHealth may include prescription medications and reason for provider visits past and future.
- I understand that my activities within MyHealth may be tracked by computer audit and that entries I make may become part of the patient's medical record.
- I understand that access to MyHealth is provided by Altru Health System as a convenience to its patients and that Altru Health System has the right to deactivate access to MyHealth at any time for any reason. I understand that use of MyHealth is voluntary and I am not required to use MyHealth or to authorize a MyHealth proxy.

MyHealth Proxy Access Form

Proxy:

I acknowledge and agree that:

- Proxy access will be deactivated on the patient's 18th birthday.
- I will comply with the terms and conditions on the MyHealth web page and this document.
- When my legal authority to act on behalf of my child has been inactivated, revoked, terminated or expired, I must immediately notify Altru Health System in writing of the revocation, termination or expiration and mail it to: Altru Health System, Attn: MyHealth Medical Records 1200 South Columbia Road, P.O. Box 6002, Grand Forks, ND 58206-6002

All fields required: Proxy #1 Information: Full Name: _____
Please print

DOB: ____/____/____ **Last 4 digits of SSN(s):** _____

Email: _____

Address: _____

Phone: _____

Proxy #2 Information: Full Name: _____
Please print

DOB: ____/____/____ **Last 4 digits of SSN(s):** _____

Email: _____

Address: _____

Phone: _____

By **signing and dating** this Proxy Access Form, I am indicating I have read and accept the MyHealth terms & conditions in this document.

➢ _____/_____ ____/____/____
Your (Proxy #1) Signature **Relationship to patient** **Date**

➢ _____/_____ ____/____/____
Your (Proxy #2) Signature **Relationship to patient** **Date**

PLEASE LEAVE FORM WITH OFFICE STAFF, OTHERWISE RETURN FORM TO:

CAVALIER COUNTY MEMORIAL HOSPITAL | ATTN: MYHEALTH MEDICAL RECORDS
909 2ND STREET
LANGDON, ND 58249
PHONE: 701-256-6186