AUTHORIZATION FOR PROXY ACCESS TO MYCITYOFHOPE – PEDIATRIC PATIENT

This form should be completed by a parent or permanent legal guardian ("Proxy") who wants to access portions of his/her child's electronic protected health information ("ePHI") maintained by City of Hope. The proxy will need to provide a copy of his/her photo identification, and if proxy is the permanent legal guardian of the patient, a copy of the court order appointing guardian and letters of guardianship verifying proxy status as permanent legal guardian of the patient must be provided. Refer to delivery methods below on how to submit that information.

Child's ("Patient") Information

FIRST NAME	MIDDLE INITIAL	LAST NAME	DOB
MEDICAL RECORD NUMBER		PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE

Parent / Permanent Legal Guardian ("Proxy") Information

In order to view the patient's information, the proxy must also obtain his/her own MyCityofHope account, but does not need to be a City of Hope patient.

FIRST NAME	MIDDLE INITIAL	LAST NAME	DOB
RELATIONSHIP TO PATIENT		PHONE NUMBER	EMAIL ADDRESS
ADDRESS	CITY	STATE	ZIP CODE

How to Submit Form:

Once completed, please forward to the Health Information Management Services Department the following methods below:

- Email: HIMS-MyCityofHope@COH.ORG
- Fax: (626) 218-8443, Attention: Health Information Management Services (ROI)
- Mail: Health Information Management Services (ROI)

  City of Hope
  1500 East Duarte Road
  Duarte, CA 91010

If you have any questions regarding this form, you may contact the Release of Information representative at 626-218-2446

General Acknowledgements

I understand that:

1. I will be using my own MyCityofHope account to access the child's MyCityofHope account.
2. I will comply with the terms and conditions on the MyCityofHope web page (located at www.mycityofhope.org then select the Terms and Conditions link on the page) and this document.
3. I will keep my password confidential and not share this information with anyone.

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4. I must have parental rights or permanent legal guardianship rights to access this child's account.
5. 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 child's medical records and/or information. If my legal status changes in relation to the child, I will notify City of Hope.
6. Communications on behalf of the child through MyCityofHope must be sent from the child's account and responses will be received in the child's account. MyCityofHope email alerts will be sent to the email address I supply when I activate my account.
7. There are age range limitations for MyCityofHope. For a child age 0 to 11 years, I will be granted full access to the child's MyCityofHope record. On the child's 12th birthday, I will be able to view a limited portion of the child's record. This age range limitations do not affect any legal right I have to access the child's record by other means. I understand that I can request a paper or other digital copy of the child's record by contacting the Health Information Management Services Department by the following methods above.
8. This authorization will expire upon the earliest of: (1) the date the child reaches the age of 18" or (2) the date City of Hope receives written revocation from the child, as an emancipated minor with legal authority to manage his/her health care. Such revocation will promptly take effect except to the extent that City of Hope already has acted based on this authorization and such refusal or revocation will not affect the commencement, continuation or quality of the patient's treatment at City of Hope.
9. I authorize the use or disclosure of ePHI.
10. I have a right to receive a copy of this Authorization.
11. I have read and understand the requirements for accessing the above named child's MyCityofHope account and agree to abide by these restrictions. I certify I am the parent or permanent legal guardian and that all information I have provided is correct. I hereby request MyCityofHope proxy access to the above named child's account.

Parent / Permanent Legal Guardian ("Proxy") Information:

SIGNATURE OF PARENT/PERMANENT LEGAL GUARDIAN (PROXY) DATE TIME

PRINTED LAST NAME PRINTED FIRST NAME PRINTED MIDDLE NAME

FOR COH USE ONLY (to be completed by staff who obtained proxy form):

1. I have given a photocopy of the signed MyCityofHope Authorization form to the Parent/Permanent Legal Guardian.
2. I have viewed the Proxy's government issued ID on (date) _____ by:

SIGNATURE OF COH STAFF PRINTED NAME OF COH STAFF

PATIENT NAME DOB MRN

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