Request for Access to a Minor Account

Send completed form to one of the following:

Email: pediatricproxy@unitypoint.org
Fax: 866-846-7864
Postal: UnityPoint Health
Attn: MyUnityPoint Reg.
118 2nd Street SE
Cedar Rapids IA 52401
Clinic: Hand in at patient's clinic

Please allow 10 business days for processing

Patient Name: _____ **Patient Date of Birth:** _____/ _____/ _____
First Middle Last

Patient Current Home Mailing Address:

_____
Street Address City State Zip Code

Patient's Clinic Name: _____ **Patient's Physician's Name:** _____

Your Name: _____ **Your E-mail:** _____
(one requestor per form)

Your Telephone Number: _____ **Your Address:** _____
(if different from the patient)

Please check your relationship to the patient:

___Mother* ____Father* ___Permanent Legal Guardian**

* You MUST have permanent legal custody of the patient to have a right to access the patient's information.

** If you are a legal guardian other than a parent, you MUST provide a copy of legal paperwork that states you have a right to this information, such as a court appointed permanent guardianship.

Is there a court or restraining order that limits your access to this patient's health information?
___ Yes (Legal documents must be provided)
___ No
The answer must be marked. If left blank, the access will be denied.

My signature represents that I have the legal right to and am asking for access to this patient's health information on the MyUnityPoint patient website. I understand when I first access this website I will need to agree to the terms and conditions.

Once approved, this form provides you online access to the patient health information when the patient is age 0 through age 11. Once the patient reaches age 12, archive view access of records from when the patient was age 11 or younger is the only online access provided. After age 11 you can still request records directly from the patient's health care team.

Once approved, the patient's records for hospital or clinic visits and treatments that currently exist will be linked to this patient website. If a new category of system records is created in the future, for a new hospital or clinic type of visit, a new consent form may be needed to allow access to those records in this patient website.

_____ _____
Printed Name of Patient's Parent or Legal Guardian Relationship to Patient

_____ _____
Signature of Patient's Parent or Legal Guardian (Electronic Signatures are NOT accepted) Date

FOR UNITY POINT HEALTH INTERNAL USE ONLY

Received date: _____

Approved _____ Denied_____ Reason:_____

Reviewer's Printed Name: _____ Reviewer's Signature_____

Reviewer's Hospital/Clinic: _____ Date_____