My Healthy Connection

Newborn to Age 11
Proxy Form

Access to Your Child's My Healthy Connection Record

To sign up for access to your child's My Healthy Connection record, please complete both pages of this Newborn to Age 11 Proxy Form and return it to the address shown below. Please note that your child's chart will be accessed through the *My Healthy Connection* portal on the Riverside Medical Clinic website www.riversidemedicalclinic.com. Completing this form will establish a My Healthy Connection record for you and your child.

Return all forms to: Riverside Medical Clinic OR Fax to: (951) 784-6480
Medical Records Dept/My Healthy Connection
3660 Arlington Avenue
Riverside, CA 92506
My Healthy Connection Hotline (951) 321-6557

Parent/Guardian Information: (All Sections required – please print clearly.)

Name *(last, first, middle initial)* ____________________

Social Security Number: ____________________ Date of Birth ____________________

Street Address: ____________________City ____________________State: ________ Zip: ________

Email Address:____________________ Phone Number: ____________________

Name of Pediatrician: ____________________

Please note the following age range limitations for My Healthy Connection. These age range limitations do not affect any legal right you have to access your child's record by other means. To request a paper copy of your child's record, contact the Riverside Medical Clinic Medical Records Department at (951) 782-4275.

- If your child is **0-11**: You will have full access to your child's My Healthy Connection record.
- When your child reaches **age 12**, you will no longer have access to your child's My Healthy Connection Record.

  ***** "The Confidentiality of Medical Information Act (CMIA)" no longer grants parents/guardians access to those accounts for children aged 12 though 17.

Please provide the following information for each child: (All fields are required. If you have more than four children for whom you would like proxy access, please request another form or print one from www.riversidemedicalclinic.com

A. Name *(last, first, middle initial)*: ____________________

Social Security Number: ____________________DOB: ____________________

B. Name *(last, first, middle initial)*: ____________________

Social Security Number: ____________________DOB: ____________________

C. Name *(last, first, middle initial)*: ____________________

Social Security Number: ____________________DOB: ____________________

D. Name *(last, first, middle initial)*: ____________________

Social Security Number: ______________________________DOB: ______________________________

▶ **Please remember to complete page 2 of this form.**

My Healthy Connection Terms and Agreement

- I understand that My Healthy Connection is intended as a secure online source of confidential medical information. If I share my My Healthy Connection 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 My Healthy Connection 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 My Healthy Connection contains selected, limited medical information from a patient's medical record and that My Healthy Connection does not reflect the complete contents of the medical record. I also understand that a paper copy of a patient's medical record may be requested from the patient's clinic.
- I understand that my activities within My Healthy Connection may be tracked by computer audit and that entries I make may become part of the medical record.
- I understand that access to My Healthy Connection is provided by Riverside Medical Clinic as a convenience to its patients and that Riverside Medical Clinic has the right to deactivate access to My Healthy Connection at any time for any reason. I understand that use of My Healthy Connection is voluntary and I am not required to use My Healthy Connection or to authorize a My Healthy Connection proxy.
- By signing below, I acknowledge that I have read and understand this My Healthy Connection Proxy Form and I agree to its terms.

▶ ______________________________ / ______________________________ / ______________________________

Signature of Parent/Guardian **Relationship to Patient** **Date** *(required)*

For Clinic Use Only:
Information Release Date: ______________________________Clinic Name: ______________________________
Name of staff member/department: ______________________________