

Access to another adult's My Healthy Connection record

To request access to the **My Healthy Connection** record of an adult patient whose medical care you help manage, please complete this form. The patient must sign this form and provide authorization for release of medical information for **My Healthy Connection** access. Please note that the patient's chart will be accessed through the **My Healthy Connection** portal on the Riverside Medical Clinic website. Completing this form will establish your **My Healthy Connection** record for the patient.

Return all forms to: Riverside Medical Clinic Attn: Health Information Management Dept.

7117 Brockton Avenue, Riverside, CA 92506

Fax to: (951) 784-6480 or Email: rmchealthinformationmanagement@uhsinc.com

My Healthy Connection Hot line (951) 321-6557

Your Information: (All sections required – please print clearly.)

This section should be completed by the individual requesting access to another adult's My Healthy Connection record.

Name (last, first, middle initial): _____

Social Security Number: _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Phone Number: _____

Patient Information: (All sections required – please print clearly.)

Complete this section with information about the patient whose My Healthy Connection record you're requesting to access.

Name (last, first, middle initial): _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Phone Number: _____

My Healthy Connection Terms and Agreement

- I understand that **My Healthy Connection** is intended as a secure online source of confidential medical information. 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 Relationship to Patient Date (required)

I acknowledge that I have read and understand this My Healthy Connection Proxy form. I agree to its terms and choose to designate the person named above as my My Healthy Connection Proxy, thereby allowing them access to My Healthy Connection record.

_____/_____/_____
Signature of Patient Relationship Date (required)