# Pediatric Patient 0 – 11 Years Request for Proxy Access

*Please allow 10 business days for processing*

**Send Completed Form to one of the following or hand in at patient's clinic**

Fax: (866) 846-7864

Postal: UnityPoint Health

Attn. MyUnityPoint Registration
3851 River Ridge Drive NE
Cedar Rapids IA 52402

Contact Technical Support: (877) 224-4430

Patient's Name: _____ Patient's Date of Birth: _____
First MI Last

Patient's Current Address: _____
Street Address City State Zip Code

Patient's Clinic: _____ Patient's Primary Care Provider: _____

Requester's Name: _____

Requester's Phone: _____ Requester's Email: _____

Requester's Current Address: _____
Address (if different from Patient) City State Zip Code

Requester's Social Security Number: _____ Requester's Date of Birth: _____

Identify your relationship to the patient: ☐ Mother† ☐ Father† ☐ Durable Power of Attorney* ☐ Legal Guardian*

† *Stepparents and foster parents are not legally entitled to proxy access. Proper documentation must be on file regarding guardianship. Please ensure you are not requesting access for a stepchild or foster child of whom you are not the legal guardian.*

* *You MUST provide a copy of legal paperwork that states you have a right to this information such as durable power of attorney or court appointed guardianship.*

## The section below MUST be completed. If left blank, access will be denied.

☐ Yes ☐ No Is there a court or restraining order that limits your access to this patient's health information?

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

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

If I am submitting this form with an electronic signature, I agree that submission of my electronic signature via Adobe EchoSign® is a valid signature that meets the requirements for a signature under federal and state law.

Printed Name of Requester _____ Relationship to Patient _____

Signature of Requester _____ Date _____

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## FOR UNITYPOINT HEALTH INTERNAL USE ONLY

Reviewer's Printed Name: _____ Hospital/Clinic Name: _____ ☐ Approved ☐ Denied

Reviewer's Signature: _____ Reason: _____ Date processed: _____