Young Adult 12 – 17 years
Request for Limited 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 Home Mailing Address:

____
Street Address City State Zip Code

Patient's Clinic: ______________________________ Patient's Primary Care Provider: ______________________

Requestor's Name: ______________________________ Requestor's Email: ______________________________

Requestor's Contact information:

____
Phone Number Address (if different from Patient) City State Zip Code

Requestor's Social Security Number: ____________________ Requestor's Date of Birth: ______________

Identify your relationship to the patient: ☐ Mother ☐ Father ☐ Durable Power of Attorney* ☐ 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?

______Limited Proxy access for child, age 12 – 17.

My signature represents that I am the personal representative for this patient, and I have the legal right toaccess this patient's health information on the MyUnityPoint patient website. I understand that in order to access the patient website, I will need to read and agree to the MyUnityPoint terms and conditions.

Once approved, the patient's immunization history will be available to me via the MyUnityPoint website. If a new category of records is made available in the future, I understand that a new consent form may be needed to allow my 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 Requestor ______________________________ Relationship to Patient ______________________________

Signature of Requestor ______________________________ Date ______________________________

FOR UNITYPOINT HEALTH INTERNAL USE ONLY

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

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