UW Medicine Request for Minor Proxy eCare Access

If you are the birth or adoptive parent or guardian of a child under the age of 13, you may use this form to request access to your child's eCare or online medical record. (Access for foster parents will be deactivated in one year.)

Patient Information:

Child's Name: _____ Last 4 Digits of Child's Social Security Number: _____
(Last, First, Middle Initial)

Date of Birth: _____

Requestor Information:

Name: _____ Relation to Child: _____
(Last, First, Middle Initial)

Requestor's Date of Birth: _____ *(needed to create proxy account)*

Address: _____

Email Address: _____ Phone: _____ Phone: _____

Photo identification of the representative must be provided *(in person, mail, email or fax)*.

Declaration and Acknowledgement

☐ I am the birth or adoptive parent of this child, ***OR***

☐ I am the legally recognized caretaker of this child. ***(Must provide documentation proving legal rights.)***

AND ☐ I have the legal right to make healthcare decisions for this child. ***(Must provide documentation.)***

- I am aware that all secure messages between persons granted proxy *e*Care access and the child's healthcare team will become part of the child's medical record.
- I will notify UW Medicine Health Information Management (contact information listed above) promptly if my legal authority to make healthcare decisions for this child changes.
- This proxy access terminates when the child reaches 13 years of age, if not deactivated for any other reason.
- I understand that I am requesting that this information be released for personal use only.
- I understand that the information in the online medical record may include sensitive information including sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services and treatment for alcohol and drug abuse.
- I understand that failure to comply with the terms and conditions of use for UW Medicine may result in the termination of my access privileges.
- Treatment will not be conditioned: I understand that the evaluation, care and treatment of my child in UW Medicine hospitals and clinics will not be influenced by my request for access to this child's online medical record.
- Potential for redisclosure: I understand that persons with proxy access to health information of the child designated on this form are not bound by law to keep it confidential.
- I understand that I may revoke this agreement by written request at any time by contacting UW Medicine Health Information Management (contact information listed below). Revoke proxy access for inpatient/hospital accounts at Harborview Medical Center and University of Washington Medical Center by calling 1-877-621-8014 (Inpatient portal eCare Support).
- I understand I have the right to receive a copy of this signed form.

PLACE PATIENT LABEL HERE

I declare under penalty of perjury under the laws of the State of Washington that the information above is true and correct.

Parent/Legally recognized caretaker Signature | City | State

Parent/Legally recognized caretaker *(Print)* | Date

For UW Medicine Staff Use Only

Request for Proxy *e*Care Access

Name of Patient for whom access is being requested: | Patient's MRN Number

- ❑ Verified patient's Date of Birth *(Patient is less than 13 years of age).*

Documentation of the Verification of Parent/Guardian Identity

Documentation to establish right as caretaker for the above-named child

- ❑ Court Order
- ❑ Medical Power of Attorney
- ❑ Other: _____
  (Description of Documentation)

After processing this request, the completed form and the photo identification must be sent to Health Information Management to be scanned into the electronic medical record.

Harborview Medical Center
UW Medical Center – Montlake
UW Medicine Neighborhood Clinics
Hall Health Center
Mail: 325 Ninth Ave., Box 359738
Seattle, WA 98104
Fax: (206) 744-9997
Phone: (206) 744-9000

UW Medical Center – Northwest
Mail: 1550 North 115th St., MS-D129
Seattle, WA 98133
Fax: (206) 668-1920
Phone: (206) 668-1616

Valley Medical Center
Mail: Release of Information
400 S. 43rd Street
P.O. Box 50010
Renton, WA 98058
Fax: (425) 656-4026
Phone: (425) 251-5159

PLACE PATIENT LABEL HERE