



AUTHORIZATION FOR OTHERS TO ACCESS MY PROTECTED HEALTH INFORMATION VIA

MyUCDavisHealth / MyUCDavisHealth Bedside

Page 1 of 2

I hereby authorize UC Davis Health to release all health information in my medical record that is available via MyUCDavisHealth / MyUCDavisHealth Bedside. This includes releasing content related to drug and alcohol abuse, mental health, HIV/AIDS test results, research, and genetic testing information as specified in the MyUCDavisHealth / MyUCDavisHealth Bedside Terms & Conditions.

PATIENT INFORMATION	GRANT MyUCDavisHealth / MyUCDavisHealth Bedside ACCESS TO <i>(Patient Representative/Proxy):</i>
PATIENT NAME	NAME
MEDICAL RECORD #	DATE OF BIRTH
BIRTHDATE	ADDRESS
	EMAIL ADDRESS <i>(required)</i>

- Patient Representative **is** a UC Davis Health PATIENT
Patient Representative Medical Record # _____
- Patient Representative **is not** a UC Davis Health Patient

Relationship to the Patient: (check one) <input type="checkbox"/> Adult for a Minor Child (age: 0-17) <input type="checkbox"/> Patient Representative of Adult Patient (age: 18+) Note: Legal documents may be required, e.g., power of attorney for healthcare, guardianship papers
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Due to California State confidentiality laws specific to teen patients between the ages of 12 to 17, Medium access is granted to the patient’s representative by Health Information Management. Full access to MyUCDavisHealth / MyUCDavisHealth Bedside could be granted to the patient’s representative when medical conditions are appropriate and are facilitated by the patient’s care team contacting Health Information Management. Medium access allows secure messaging, appointment requests and access to immunization summary and allergies.

The purpose of this request is for: <input type="checkbox"/> New Access <input type="checkbox"/> Access Renewal



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NOTICE / Restriction: California law prohibits patient representative from making further disclosure of the patient’s health information, unless the recipient obtains an additional authorization from the patient or the disclosure is required or permitted by law. The state of federal confidentiality law protections may not extend to recipients outside the State of California, or to someone who is not legally required to keep it confidential.

Information available in MyUCDavisHealth / MyUCDavisHealth Bedside includes current medical information and will update as you continue to receive health care services in the future.

YOUR RIGHTS: As the Patient/Patient Representative, you have the right to request a copy of this authorization. A copy is considered as valid as the original. Refusal to sign this request will not affect the patient’s right to obtain treatment. The patient/patient representative may revoke access at any time via their MyUCDavisHealth / MyUCDavisHealth Bedside Account. Revocation may also be submitted to the Health Information Management Department via mail, fax or email. Revocation will take effect immediately upon receipt of your revocation request or based upon the request from UC Davis Health Providers. You may submit the completed Request to Access MyUCDavisHealth / MyUCDavisHealth Bedside form, along with any required documentation for Request of Revocation by any of the following methods:

Fax: 916-734-2126 **Email:** hs-myucdavishealthactivationteam@ucdavis.edu

US Mail: UC Davis Health, Health Information Management
Medical/Legal Release of Information Unit
2315 Stockton Blvd., Sacramento, CA 95817

EXPIRATION OF AUTHORIZATION: Unless otherwise revoked, this authorization for MyUCDavisHealth / MyUCDavisHealth Bedside access **will expire** on _____ or as restricted by access level/relationship type, agreed upon in the MyUCDavisHealth / MyUCDavisHealth Bedside Terms & Conditions.

By signing below I authorize the MyUCDavisHealth/MyUCDavisHealth Bedside access disclosure and I have read, understand and agree to the MyUCDavisHealth / MyUCDavisHealth Bedside Terms & Conditions. I authorize all lab/test results to be released automatically via MyUCDavisHealth / MyUCDavisHealth Bedside and understand that in some cases, lab/test results will be released without prior provider review or without prior consultation between the patient and the health care provider.

Print Name of Patient

Signature of Patient

Print Name of Patient Representative

Signature of Patient Representative

Date

Relationship to Patient