



(Adult) Authorization Form to Allow Access to My Health Connection

I understand that by filling out this form, I authorize the individual listed below to have access to all of my health information that is contained in my UCHealth “My Health Connection” (MHC) account.

Please print clearly. All items are required.

PATIENT:		AUTHORIZED INDIVIDUAL:	
Full Name		Full Name	Gender
Date of Birth	Med. Record #	Date of Birth	SS#
Address		Address	
City/State	Zip Code	City/State	Zip Code
Phone	E-mail	Phone	E-mail

As the patient, I acknowledge, understand and agree to the following:

- This authorization is voluntary and made at my request.
- The authorized individual must follow the terms of use for MHC. These terms of use can be found on the website for MHC. If the authorized individual violates the terms of use for MHC, his/her access to MHC may be terminated.
- Once I authorize the disclosure of my health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected.
- My treatment will not change if I authorize access to MHC or subsequently revoke it.
- **By signing this form, I am granting the authorized individual the ability to view my electronic health record which may include employee health appointment information, mental health notes, Human Immunodeficiency Virus (HIV) results, Sickle Cell results, Alcohol and Substance Abuse treatment, as well treatment for Sexually Transmitted Disease/Communicable Diseases.**
- I must log in to MHC with my own user name and password.
- Any communications through MHC made by the authorized individual will become part of my medical record.
- I can revoke my authorization by logging into MHC in the “Family Access” section and clicking the box next to the authorized individual’s name and selecting “Revoke Access.” This will remove the authorized individual’s ability to access my MHC account immediately. I can also request revocation in writing by copying, faxing or scanning this form to one of the locations listed below and it will be processed upon receipt. I understand any revocation will not apply to information that has already been released in response to this authorization.
- This authorization expires 10 years from the date of my signature below, unless otherwise specified herein.
Other: _____
(To renew the authorization, a new authorization will be required.)

Signature of Patient or Authorized Representative*

Date

* If signing as authorized representative, you must notify UCHealth when your legal authority to act on behalf of the patient has been inactivated, revoked, terminated or expired. You can do this in writing by mailing it to one of the addresses below.

Please return all pages of this form to one of the following locations:

Memorial Hospital Health Information Management Department (Room 2402) Attn: Release of Information 1400 E. Boulder Street Colorado Springs, CO 80909	University of Colorado Hospital Health Information Management Attn: Release of Information Mailstop AO25 12401 E. 17th Avenue Aurora, CO 80045	Medical Center of the Rockies Poudre Valley Hospital Health Information Management Attn: Release of Information 2500 Rocky Mountain Avenue Loveland, CO 80538
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TO BE COMPLETED BY AUTHORIZED INDIVIDUAL:

In order to be given access to the above named patient's MHC account, I understand that I must have my own MHC account at UCHealth. If I do not have an MHC account, UCHealth can assist me in creating one. In order to grant my access, UCHealth needs the following information:

1. Have you been a patient at UCHealth? Yes No
2. If yes, do you have an active UCHealth MHC account? Yes No
3. Your relationship to the patient: _____
4. If patient is not able to make and understand his or her health care decisions, have you been designated as one of the following for the patient?

Permanent Legal Guardian or Conservator

(Authorized Individual must show copy of Photo ID and attach copy of the Legal Paperwork Appointing Guardianship or Conservatorship)

Medical Durable Power of Attorney (MDPOA)

(Authorized Individual must provide Photo ID and copy of MDPOA)

Confirmed on date: _____ By: _____
(UCHealth employee signature/title)

As the authorized individual, I acknowledge, understand and agree to the following:

- I must follow the terms of use for MHC. These terms of use can be found on the website for MHC. If I violate the terms of use for MHC, my access to MHC may be terminated. I must log in to MHC with my own user name and password.
- My communications through MHC will become part of the patient's medical record.
- The patient can revoke my access to his/ her MHC account at any time.
- My access to the patient's MHC account will expire 10 years from the patient's signature date on this authorization unless otherwise specified. To renew the authorization, a new authorization will be required.

Authorized Individual Signature

Date

Please return all pages of this form to one of the following locations:

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