INTEGRIS

MINOR CHILD PROXY REQUEST

Access to Your Child's INTEGRIS & Me Record

To sign up for access to your child's INTEGRIS & Me record, please complete this Child Proxy form. Please note that your child's chart will be accessed through your INTEGRIS & Me record. Completing this form will establish an INTEGRIS & Me record for you and for your child. Please provide a government-issued ID for identity verification when submitting this form.

Return forms to your INTEGRIS health care provider. If you don't have an INTEGRIS provider, please submit to: INTEGRIS Health Information Department, Release of Information, 3366 N.W. Expressway, Building D, Suite C20, Oklahoma City, OK 73112 or fax to 405-552-8704. For questions call, 877-778-7211.

PARENT or GUARDIAN INFORMATION (All Sections Required - Please Print Clearly)
This section should be completed by the individual requesting access to a minor child's INTEGRIS & Me record.

NAME – *LAST, FIRST, MIDDLE INITIAL*	◯ *Male* ◯ *Female*	DATE OF BIRTH	Social Security Number
STREET ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER ◯ *Home* ◯ *Work* ◯ *Cell*	EMAIL ADDRESS		

Please note the following age range limitations for INTEGRIS & Me. These age range limitations do not affect any legal right you have to access your child's record by other means consistent with INTEGRIS policy and state and federal laws. To request a paper copy of your child's record, contact the Health Information Management Department at INTEGRIS Health.

- Once your child reaches **12 years of age,** you will no longer have access to your child's INTEGRIS & Me record, unless your child consents to access.
- If your child has the right under Oklahoma law to consent for his/her treatment before 18 years of age, you may not be granted access to your child's INTEGRIS & Me record, unless your child consents to your access.

CHILD'S INFORMATION (All Sections Required - Please Print Clearly)
Complete this section with information for the child for whom proxy is requested.

NAME – *LAST, FIRST, MIDDLE INITIAL*	◯ *Male* ◯ *Female*	DATE OF BIRTH	LAST 4 NUMBERS OF SSN
STREET ADDRESS	CITY	STATE	ZIP CODE

INTEGRIS & Me TERMS and AGREEMENT

- I understand that INTEGRIS & Me is intended as a secure online source of confidential medical information. If I share my INTEGRIS & Me ID and password with another person, that person may be able to view my or my child's health information, and health information about someone for whom I have INTEGRIS & Me proxy.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.
- I understand that INTEGRIS & Me contains selected, limited medical information from my child's medical record and that INTEGRIS & Me does not reflect the complete contents of the medical record. I also understand that a paper copy of my child's medical record may be requested from the Health Information Management Department at INTEGRIS Health.
- I understand that my activities within INTEGRIS & Me may be tracked by computer audit and that entries I make may become part of the patient's medical record.
- I understand that access to INTEGRIS & Me is provided by INTEGRIS Health as a convenience to its patients and that INTEGRIS Health has the right to deactivate access to INTEGRIS & Me at any time for any reason. I understand that use of INTEGRIS & Me is voluntary and I am not required to use INTEGRIS & Me or to authorize an INTEGRIS & Me proxy.
- If the proxy's legal relationship with the patient changes, INTEGRIS Health must be informed immediately by sending written notice to your INTEGRIS health care provider.

By signing below, I acknowledge that I have read and understand this INTEGRIS & Me sign-up document and the attached Terms and Conditions, and attest that I am the parent or legal guardian of the above named minor child.

PARENT / LEGAL GUARDIAN SIGNATURE	DATE
PRINTED NAME	RELATIONSHIP TO PATIENT

MINOR CHILD PROXY REQUEST

Authorization for Release of Medical Information to Adult Proxy

This form is an authorization that will permit INTEGRIS Health to release your medical information to your designated adult proxy. Please read it carefully.

This form should be completed by the patient who is authorizing another adult to access medical information in his or her INTEGRIS & Me record. It must accompany the Minor Child Proxy Form, which provides the name and information of the individual who the patient is authorizing to access their INTEGRIS & Me record as a proxy.

PATIENT NAME – *LAST, FIRST, MIDDLE INITIAL*	◯ *Male* ◯ *Female*	DATE OF BIRTH	LAST 4 NUMBERS OF SSN

I am requesting that _____ *(insert name of proxy)* receive access to my health information that is available in my INTEGRIS & Me Record. This person is my designated INTEGRIS & Me proxy. I authorize INTEGRIS Health to release the health information contained in my INTEGRIS & Me record to my INTEGRIS & Me proxy. I understand that the medical information in INTEGRIS & Me is obtained from my electronic medical record and may include information from other INTEGRIS Health facilities. I authorize release of any information contained in my INTEGRIS & Me medical record held by INTEGRIS Health to my designated proxy.

I authorize release of this information only through my INTEGRIS & Me record. This form does not authorize release of my medical record to my designated proxy by other methods or in other forms.

I understand that once information has been disclosed, it potentially may be re-disclosed by the proxy and the disclosed information may not be covered by federal privacy protections.

Participation in INTEGRIS & Me and designating a INTEGRIS & Me proxy is completely voluntary. I understand that I am not required to designate a INTEGRIS & Me proxy and I am not required to provide this authorization. I also understand that INTEGRIS Health does not condition any of my health care treatment, payment or other services on whether I provide this authorization. However, I also understand that if I do not provide authorization, INTEGRIS Health is not permitted to provide access to my INTEGRIS & Me record to my designated proxy.

This authorization will expire upon revocation, or on the date or event specified here _____.
I also may revoke this authorization at any time by providing a written request for revocation to INTEGRIS Health.
I understand that if I revoke this authorization, my designated proxy's access to my INTEGRIS & Me record will be ended. I also understand my revocation will not affect any disclosures that were made prior to processing the revocation request.

PATIENT SIGNATURE (OR AUTHORIZED PERSON)	DATE
PRINTED NAME	RELATIONSHIP TO PATIENT

FOR INTEGRIS HEALTH SYSTEM USE ONLY

Signature Verification:
◯ Verified by ID (Driver's License, State ID, Military ID) ◯ Form signed in person ◯ Signature on file

SIGNATURE VERIFIED BY	DATE

Send to Health Information Management Department for final verification and granting of proxy access.