REQUEST FOR PROXY ACCESS FOR CHILDREN UNDER 12

PATIENT'S INFORMATION

Patient's Name: ______________________________ Patient's Date of Birth: ______________

Address:______________________________City:__________ State: ________ Zip: __________

Existing My Genesis account? ☐ Yes ☐ No

PROXY'S INFORMATION

Proxy's Name: ______________________________ Proxy's Date of Birth: ______________

Address:______________________________City:__________ State: ________ Zip: __________

Email: ______________________________ Existing My Genesis account? ☐ Yes ☐ No

Telephone:______________________________

Relationship to Patient: ☐ Father ☐ Mother ☐ *Legal Guardian ☐ *Other
(*Legal documentation is required)

My signature represents that I have the legal right to, and am asking for access to, this patient's health information on My Genesis. I understand when I first access the patient website; I will need to agree to the My Genesis terms and conditions. Once approved, the patient informational records for hospital or clinic visits and treatments that currently exist will be linked to the My Genesis patient website.

This agreement will continue until cancelled by the patient/guardian or automatically once the child reaches age 12. Access can be cancelled on-line at www.genesishealth.com/MyGenesis by completing the "Revoke Access to My Genesis" form.

Printed Name of Proxy: ______________________________ Relationship to Patient: ______________

Signature of Proxy: ______________________________ Date: ______________

Mail Completed Form to:

Genesis Health System
Health Information Management
My Genesis Proxy Access
1227 East Rusholme Street
Davenport, IA 52803

OFFICE USE ONLY
Verified and access entered by: ______________________________ Date: ______________