



Patient and Family Request for Access to My Care Connection Online Patient System

I hereby request access to the My Care Connection Online Patient System maintained by Cincinnati Children's Hospital Medical Center (CCHMC) for the patient named below (Patient). I understand that CCHMC takes seriously its responsibility to safeguard the privacy of its patients and protect the confidentiality of their protected health information. Therefore, I will only access My Care Connection in a manner consistent with these terms.

I will safe keep the sign-on and password that I am assigned and will not share my log-in information with anyone else. I agree that CCHMC will not be liable for any disclosure of information due to unauthorized use of my sign-on and password. If I feel my sign-on/password combination has been compromised, I will contact the appropriate CCHMC clinic immediately. I understand that I can then either change my password using the tools provided or have the clinic direct me to someone who can assist me.

I understand that My Care Connection should only allow me to view records for the Patient. If I accidentally gain access to another patient's information, I will cease to view it and will notify the appropriate CCHMC clinic immediately. In no event will I deliberately attempt to access information for any person other than the Patient through My Care Connection.

I represent to CCHMC that I am (i) the Patient, (ii) a personal representative of the Patient with the right to access the Patient's protected health information, or (iii) a person whom the Patient has expressly authorized to have access to the Patient's protected health information. If my status as a personal representative changes so that I no longer have such right, or if the Patient's authorization expires or is revoked, I will immediately cease using My Care Connection to access the Patient's information and will notify the appropriate CCHMC clinic.

Print Patient's Name: _____

Patient's Date of Birth: _____ MRN: _____

By signing below, I agree to abide by these terms and understand that a violation may result in my loss of access to My Care Connection.

Print Name of Person Requesting Access _____ Relationship to Patient _____

Signature of Person Requesting Access _____ Date _____

Email _____

Login ID _____

Secret Knowledge Information:

Question _____

Answer _____

Please fax or mail this completed form to the appropriate CCHMC Clinic.

Cincinnati Children's
Hospital Medical Center
Clinic Contact Information

Diabetes Center A3S
MLC 5006
3333 Burnet Avenue
Cincinnati, OH 45229-3039
(513) 636-2444 Office
(513) 636-2444 Portal
(513) 636-3331 Fax
Diabetescenter@cchmc.org

Kidney Transplant Program
MLC 7022
3333 Burnet Avenue
Cincinnati, OH 45229-3039
(513) 636-4531 Office
(513) 636-7407 Fax
Nephrology@cchmc.org

Pulmonary Medicine, CF Center
ML 2021, C - 5
3333 Burnet Avenue
Cincinnati, OH 45229-3039
(513) 636-6771 Office
(513) 636-8663 Portal
(513) 636-4615 Fax
CF_Portal_Moderator@cchmc.org

Rheumatology Center
MLC 4010
3333 Burnet Avenue
Cincinnati, OH 45229-3039
(513) 636-4676 Office
(513) 636-6660 Portal
(513) 636-5568 Fax
RheumatologyPortal@cchmc.org

Pediatric Liver Care Center
MLC 3022, D3.77
3333 Burnet Avenue
Cincinnati, OH 45229-3039
(513) 636-4955 Office
(513) 636-9857 Portal
(513) 636-5980 Fax
www.cinincnatchildren.org/liver