



## Patient and Family Request for 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 a personal representative of the Patient with the right to access the Patient's protected health information, or that the Patient has expressly authorized me to have access. 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 Parent/Legal Guardian/Patient's Name Relationship

Signature of Parent/Legal Guardian/Patient 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