Trinity Health

IHA Medical Group

MyChart® Child Teen Access Form
Ages 12-17

Allowing your Teen to Access their MyChart® Record.

To allow your teen access to their MyChart record, please provide the information requested below.

Please read this information carefully.

Please provide the following information for Minor: (All fields are required)

Patient Name *(last, first, middle initial)*: _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Phone Number: _____

Parent/Guardian/Proxy Information: (All sections required – please print clearly.)

Name (*last, first, middle initial*) _____ Date of Birth: _____

Relationship to Patient: _____ Phone Number: _____

Address if different than Minor: _____

Limited Access

Please note the following age range limitations regarding Proxy access to medical information of a Minor via MyChart®. These limitations have been established in order to comply with Federal and State laws and regulations regarding the release of health information of a minor. These age range limitations apply to the use of MyChart® only, and do not affect any legal rights of the minor patient or parent/legal guardian to access the minor patient's record or medical information by other means. To request additional information from your child's record, contact your child's primary care provider. Copies of medical records or other medical information outside of MyChart® are released only with proper authorization and in accordance with Federal and State laws and regulations, and policies and procedures.

- **Age 12-17**, Minor can be granted "Patient access – teen" access, with parents' permission:
    - Minor teen will have access to certain protected health information that the patient's provider determines may be posted to MyChart in accordance with State and Federal laws and Regulations and in accordance with Policies and Procedures.

Terms & Conditions

- Full terms and conditions will be addressed within MyChart application. I will have the opportunity to review and consent to the full terms and conditions via MyChart.
- I, Parent/Guardian/Proxy, and Minor Patient understand that the medical providers who are responsible for my child's care may rely upon information provided by Parent/Guardian/Proxy or Minor Patient in MyChart®. **I understand that I must provide complete and accurate information.** I further understand that I am solely responsible for any action taken by care providers in reliance upon any entries I make in MyChart® and/or the medical record.
- I, Parent/Guardian/Proxy, and Minor Patient understand that access to MyChart® is provided by child's physician as a convenience to patients and parents of minor patients and maintains the right to deactivate access to MyChart® at any time for any reason. We understand that use of MyChart® is voluntary and we are not required to use MyChart®
- I, Parent/Guardian/Proxy understand that if all parent/legal guardian rights to my child are revoked, my access to my child's MyChart® access will also be revoked.
- **I, Parent/Guardian/Proxy, and Minor Patient understand that MyChart® is not to be used in an emergency.**
- I understand that I may revoke this authorization at any time by providing a written request to my providers office. I understand that if I revoke this authorization, designated access to MyChart record will end.

By signing below, I, Parent/Guardian/Proxy acknowledge that I have had the opportunity to discuss this authorization with a representative of the provider and have had any questions satisfactorily answered. I agree to only use this access for the sole purpose of assisting in the medical management of the minor patient.

Check option that applies (i.e. In person signature Parent/Guardian signature or Verbal consent obtained):

☐ I, Parent/Guardian/Proxy, authorize for my teen to have "Patient access – teen" MyChart access

▶ _____ / _____ / _____

Signature of Parent/Guardian/Proxy **Relationship to Patient** **Date**

☐ **Verbal consent** obtained from Parent/Guardian/Proxy, authorize for my teen to have "Patient access – teen" MyChart access

▶ _____ / _____ / _____ / _____

Name of Parent/Guardian/Proxy **Relationship to Patient** **Staff Name***(Required)* **Date**

For Office Use Only
Date Completed : _____
Employee confirmed appropriate relationship and/or documentation for requested proxy consent - Employee Initials: _____
Location that completed MyChart Proxy Consent:_____