

# MyChart Child Proxy Request

(Proxy Access for minors up to age 13 years)

## 1. Child Patient Information

Patient Name (last, first, middle initial)	Date of Birth	Medical Record Number (Optional)	
Street Address	City	State	Zip

## 2. Proxy Information (Parent/Guardian)

Proxy Name (last, first, middle initial)	Date of Birth
Street Address	City
	State
	Zip
Email Address	Phone Number

Does the proxy have an active MyChart account?  Yes  No

Has the proxy ever been a patient at one of our health care facilities?  Yes  No

### Child Proxy Relationship

#### Access to your minor child's MyChart record

- Individuals requesting access must have parental rights or legal guardianship rights.

#### My Relationship to the Child is:

Parent

Legal Guardian of the Patient - Must attach a copy of the Court Order Appointing Guardian and Letters of Guardianship verifying the Proxy's status as legal guardian of the patient.

#### By signing below, parent/guardian acknowledges and agrees that:

- I have parental rights or legal guardianship rights to access this child's record.
- I have not been denied periods of physical placement with the child and there are no court orders or restraining orders in effect limiting my access to this child's medical records and/or information.
- Generally, I will be granted full access to the child's MyChart record until the child's 13th birthday. On the child's 13th birthday, I will no longer have access to the child's MyChart record unless the child authorizes me to access any specially protected information - mental health, reproductive services, HIV and AIDS and chemical dependency.

Patient Name: \_\_\_\_\_

DOB: \_\_/\_\_/\_\_\_\_

**Note that state law may control the access discussed in this request. State law may allow access until the child reaches the age of majority, obtains adult rights as recognized by the state, or reaches other milestones identified in the law.**

**LEGAL GUARDIANS**

I confirm that any documents I have provided in support of my right to access the patient's protected health information, are true and correct copies and are the most recent documents related to this matter. When my legal authority to act on behalf of the patient has been inactivated, revoked, terminated, or expired, I must immediately notify the health care facility in writing of the change in authority and mail it to the Health Information Management Department.

Parent or Legal Guardian Signature (Required)	Date (Required)
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<b>For Office Use Only:</b>	Date Granted	User's Initials
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