MyChart Parent Proxy Authorization Form

This form is an authorization that allows Memorial Healthcare System ("MHS") to release your medical information to your parent(s) (a "proxy") so that they can access your MyChart records on your behalf.

Patient Name (last, first, middle initial)	
Last 4 digits of Social Security Number	
Date of Birth	
Street Address	
City	
State	
Zip Code	
Telephone number	

Usually, the law lets your parent(s) read your health records and talk to doctors and others giving you health care without getting your permission, as long as you are under the age of 18. You and your parent(s) are being given this form because there are a few situations in which minors can consent to medical treatment on their own, without their parents being told. In those situations, the minors have the right to keep related medical information confidential—even from their parents. As used in this form, the term "parent" includes legal guardians.

These special circumstances include treatment of sexually transmissible diseases, drug or alcohol addiction, pregnancy, and certain mental health outpatient care. By signing, this, I allow MHS and its facilities, including physician practices, to release to_____
_____
[name of parent(s)] health information contained in my MyChart record. I understand that the information disclosed may include, but is not limited to lab tests [past, present and future], physician office visits, and other communications with my healthcare providers.

I agree with the following statements:

a. I understand that I may change my mind and withdraw this authorization at any time.

b. This authorization will continue until withdrawn by me, but not longer than (please check one): ___ in six months, or ___ in one year, or ___ indefinitely. This authorization will automatically expire when I turn age 18.

c. If I sign this form, I understand that my parents will have access to information for treatment I may have for sexually transmitted diseases including AIDS or HIV, mental or behavioral health or psychiatric care, treatment of drug or alcohol abuse or pregnancy.

d. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the party who receives it because it may no longer be protected by the federal privacy laws.

e. I understand that records in electronic form can be distributed on a wide scale with relative ease and losses or unintended releases of the requested information may occur under circumstances beyond the control of MHS, or the person making the request. By authorizing access to records in this format, I am knowingly and voluntarily assuming this risk and all of the consequences, losses and damages that might result.

f. I understand that Memorial Healthcare System may not condition treatment, payment, enrollment or eligibility of benefits on the completion of this authorization.

g. This information will be used and disclosed for the purpose of providing the designated individual access to my Memorial MyChart records.

h. I have read, understand, and accept the terms of use for MyChart.

Signature of Patient	
Date	

AND

Signature of Patient's Parent(s)	
Date	
Printed name of Patient's Parent(s)	
Telephone Number(s)	
Relationship to Patient/Authority to act for Patient	

For help with this document, please contact your MyChart Provider's Office or email MyChart@mhs.net. Thank you.