Parent/Guardian Access to the Online MyChart Record of a Patient 12 to 17 Years Old - Authorization Form

Please enter **Patient's** information below:

Patient's Name: _____

Address: _____ Date of Birth: _____

Gender: _____ Male _____ Female

To be notified when new messages about the patient's care are sent to MyChart, please list an e-mail address:

_____

Please enter **Parent/Legal Guardian** information below:

Parent Name: _____ Date of Birth: _____

Address: _____

Phone number on file: _____

Relationship to patient: ____*Parent* ____ *Legal Guardian* ____ *Other* (please specify:_____)

Note: Access to patient's online record is only available to parents or individuals with legal guardianship.

Do you (parent/legal guardian) have an active MyChart account? _____Yes _____ No

I have read and understand the requirements and procedures for accessing my child's medical record information online as provided on page one of this document titled, Parent/Guardian Access to the Online MyChart Record of a Patient 12 to 17 Years Old. I certify that I am the parent or legal guardian of the child listed above and that all information I have provided is correct. I hereby request access to my child's online record. This authorization is valid until it is revoked or otherwise expires.

_____ _____

Date Parent/Legal Guardian Signature

For Patient (12-17)

I authorize the release of information covering the period(s) of healthcare starting with the first date of service that information became available in the Lurie Children's online system (laboratory results as early as 2002 and medical imaging starting 2004) to my 18th Birthday - Date (/ /).

I agree to allow my parent/legal guardian, named above, online access to my medical information currently available and that may become available as a result of future medical care. I understand I may revoke this access at any time.

I understand that the following items may be disclosed along with other health information in my medical record: HIV/AIDS related health information and/or records, behavioral or mental health information and/or records, information about sexually transmitted disease (STD), pregnancy, birth control, drugs/alcohol diagnosis, treatment, and/or referral information, genetic testing information and/or records, information about sexual assault/abuse, information about child abuse and neglect, and domestic abuse of an adult with a disability.

_____ _____

Date Patient Signature

_____ _____

Date Witness Signature
(anyone other than parent or patient may witness)

_____

Witness Printed Name