

# MyChart Teen Proxy Authorization

## Teen Minor Information (Age 13 – 17)

Patient Name: \_\_\_\_\_ [ ] Male [ ] Female

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Address: \_\_\_\_\_

Relationship to minor/child:

Parent  Legal Guardian  DCF Representative  Foster Parent  Other: \_\_\_\_\_

*\*\*Legal documentation of guardianship is required, if applicable (e.g. court order, adoption decree, etc.)*

## Parent/Guardian Information

Parent/Guardian Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Contact phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Address: [ ] Same as minor *If different:* \_\_\_\_\_

### **MyChart Terms and Conditions:**

- I understand this request for full access to my teen minor's MyChart account must be authorized by my teen minor and my teen minor's health care provider when considered in the best interest of my child due to special health care needs. My teen minor is also eligible to activate his/her own MyChart account.
- Access to my teen minor's MyChart account will expire upon his/her eighteenth birthday. Prior to that date, my teen minor may choose to limit my access to certain information which is protected by state law.
- MyChart includes a limited set of medical information including diagnostic test results, medications, allergies, and immunizations. A complete copy of medical records may be requested from my teen minor's health care provider.
- For a complete list of Terms and Conditions, please visit: <https://mychart.ynhhs.org/mychart-PRD/default.asp?mode=stdfile&option=termsandconditions>

### **By signing below, I agree to the following:**

- I am entitled to access the patient's protected health information as his/her parent or legally appointed guardian.
- My rights to access the patient's protected health information have not been modified in any manner by any court of law.
- The documents I have provided in support of my right to access the patient's protected health information, if any, are true and correct copies and are the most recent documents related to this matter.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Teen Minor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*\*\*For proxy activation, send completed form and legal documentation, if applicable, to:*

*Fax: 203-688-8155 or E-mail: [MyChart.eHIM@ynhh.org](mailto:MyChart.eHIM@ynhh.org)*

*For Office Use Only:*

Patient MRN: \_\_\_\_\_

Proxy Activation Date: \_\_\_\_\_

