

MyChart Minor Proxy Authorization

Minor/Child Information	
Patient Name: _____ [] Male [] Female	
DOB: _____ Age: _____ Address: _____	
Relationship to minor/child:	
<input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> DCF Representative <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other: _____	
<i>**Legal documentation of guardianship is required, if applicable (e.g. court order, adoption decree, etc.)</i>	
Parent/Guardian Information	
Parent/Guardian Name: _____	
DOB: _____ Contact phone: _____ Email Address: _____	
Address: [] Same as minor <i>If different:</i> _____	

MyChart Terms and Conditions:

- Full access to a minor/child's MyChart account automatically expires at the age of 13 and will be replaced with limited MyChart access to comply with state law which requires privacy of certain protected health information. An email notification will be sent at least 30 days in advance of any changes in MyChart access.
- A minor who is a teen (age 13 – 17) may activate his/her own MyChart account. In addition, if a teen minor has special health care needs, full proxy access may be obtained by the parent/legal guardian after discussion with the teen minor's health care provider. This access is obtained by completing a Teen Minor Proxy Authorization form.
- 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 the child'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: _____

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

Fax: 203-688-8155 or E-mail: MyChart.eHIM@ynhh.org

For Office Use Only:

Patient MRN: _____	Proxy Activation Date: _____
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