MyChart – Access Authorization with Minor Proxy

YALE NEW HAVEN HEALTH

Minor/Child Information

Complete one authorization per minor child less than 18 years of age.
All fields are required.

Patient Name: _____ [ ] Male [ ] Female

Relationship to Parent/Guardian: _____ DOB: _____ Age: _____

Parent/Guardian Information

All fields are required.

Parent/Guardian Name: _____ DOB: _____

Address: _____ Email address: _____

City, State, Zip: _____ Phone Number: _____

MyChart Terms and Conditions

I understand the following:

- MyChart contains selected, limited medical information from a patient's medical record and does not reflect the complete contents of the medical record. A paper copy of a patient's medical record may be requested from the patient's health care provider.
- My activities within MyChart are tracked by computer audit, and entries I make can become part of my medical record or my minor child's medical record.
- My access to certain information about my minor child will be limited upon my minor child's thirteenth birthday in accordance with Connecticut state law. At this time, my teen minor will also be eligible to activate his/her own MyChart account.
- If my teen minor has special health care needs, my child's provider may authorize full access to his/her MyChart account if considered to be in his/her best interest. My teen minor may also authorize my full access to his/her MyChart account after discussion of privacy rights with his/her provider.
- A reminder regarding any changes to my teen minor's MyChart account will be sent via message to the email listed on the proxy account 30 days in advance of the change. I understand I will receive the email notification and then will need to login to view the message.
- I agree to abide by the Yale New Haven Health System MyChart Terms and Conditions, which are available at https://mychart.ynhhs.org/mychart-PRD/default.asp?mode=stdfile&option=termsandconditions

By signing below, I acknowledge that I am providing documentation of my authorization to access the protected health information of the minor child described above. I certify that I am the parent or the legal guardian for the patient named above, and that the information I have provided is true and correct.

Parent/Guardian Signature: _____ Date: _____

For Office Use Only

Patient MRN:	Proxy Activation Date: