YaleNewHavenHealth

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/GuardianName:_____

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*

For Office Use Only:

Patient MRN:	*Proxy Activation Date:*