SALEM Township HOSPITAL

MyChart Child 12-17 Proxy Authorization Form

MyChart is a service provided by Salem Township Hospital & OSF Healthcare

Parent/Legal Guardian Access to the MyChart Account of a Patient 12-17 Years Old

Requirements and Procedures

Under State and Federal law there are certain types of medical information that the parent or legal guardian of a minor patient age 12-17 may not view without consent of the minor patient. Because of these requirements, a parent or legal guardian may access the online MyChart account of a patient 12-17 years old only with the patient's consent. Both the child ages 12-17 and the parent/legal guardian must sign this form.

Requirements for accessing a child's account:

- ✓ Birth parent or individual requesting access must have legal guardianship rights.
- ✓ Proxy authorization form must be completed and signed.
- ✓ Each parent or individual requesting access must have their own MyChart account or an MyChart account will be established for them.

I understand that:

- ✓ I must have an MyChart account or an account will be established for me.
- ✓ I must log in to MyChart with my own user ID and password.
- ✓ I agree to abide by the terms and conditions of the MyChart site.
- ✓ MyChart is not to be used in an emergency.

Parent/Legal Guardian access to a child's account is revoked when:

- ✓ Parent/Legal Guardian submits a written request to revoke their own access or revokes their access online.
- ✓ Child submits a written request to revoke their parent/legal guardian's access.
- ✓ Child turns 18 years old.
- ✓ Child advises our healthcare facility of his/her emancipated status.
- ✓ Parent/parent or parent/child access disputes cannot be resolved.

Salem Township Hospital reserves the right to revoke online access to medical information at any time.

MyChart Terms and Agreement

- ✓ I understand that OSF Healthcare System has been contracted by my provider to provide OSF MyChart.
- ✓ I understand that MyChart is intended as a secure online source of confidential medical information. If I share my MyChart ID and password with another person, that person may be able to view my or my child's health information, and health information about someone who has authorized me as an MyChart proxy.
- ✓ I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.
- ✓ I understand that MyChart contains selected, limited medical information from a patient's medical record and that MyChart does not reflect the complete contents of the medical record. I also understand that a paper copy of a patient's complete medical record may be requested from the applicable provider.
- ✓ I understand that my activities within MyChart may be tracked by computer audit and that entries I make may become part of the patient's medical record.
- ✓ I understand that access to MyChart is provided by OSF Healthcare System as a convenience to its patients and that OSF Healthcare System and/or my physician has the right to deactivate access to MyChart at any time for

any reason. I understand that use of MyChart is voluntary and I am not required to use MyChart or to authorize an MyChart proxy.

- ✓ By signing below, I acknowledge that I have read and understand this form and I agree to its terms. I further agree to any and all current and future terms and conditions noted on the MyChart site.

Parent(s)/Legal Guardian(s) Information: (All fields are required - please print clearly).

Last Name: _____ First Name: _____ Middle Initital: _____

Gender: ☐ Male ☐ Female Last 4 Digits of Social Security Number: XXX-XX- _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Last Name: _____ First Name: _____ Middle Initital: _____

Gender: ☐ Male ☐ Female Last 4 Digits of Social Security Number: XXX-XX- _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

To be notified when new messages about the patient's care are sent to MyChart,

please list one email address: _____

Please enter Patient/Child Information below: (All fields are required - please print clearly).

Last Name: _____ First Name: _____ Middle Initital: _____

Gender: ☐ Male ☐ Female Last 4 Digits of Social Security Number: XXX-XX- _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Provider's Name/Office (if known): _____

SALEM Township HOSPITAL

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

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 form titled, Parent/Legal Guardian Access to the MyChart Account of a Patient 12-17 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 true and correct. I hereby request access to my child's online account.

► _____ / _____ / _____

Signature of **Parent/Legal Guardian** Relationship to Patient Date (Required)

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For Patient (12-17 years of age)

I understand I have the right to control access to the following types of information: 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, and information about child abuse and neglect. I understand that the items listed above may be disclosed along with other health information in my MyChart account.

I agree to allow my parent(s)/legal guardian(s), named above, online access to my medical information currently available and information that may become available as a result of future medical care. I understand this authorization will expire automatically upon my 18th birthday. I also understand that I have the right to revoke this authorization at any time. My request to revoke parental access must be submitted in writing and may take several days to process.

► _____ / _____

Patient/Child Signature Date (Required)

► _____ / _____

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

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