

MyChart PEDIATRIC (AGE 0-17) PROXY ACCESS FORM

This form is to be completed in the clinic and left with office staff.



Access to my child/children's (age 0 -17) MyChart Record (please print)

Name of Child #1: _____

DOB: ____/____/____

Name of Child #2: _____

DOB: ____/____/____

Name of Child #3: _____

DOB: ____/____/____

Name of Child #4: _____

DOB: ____/____/____

Please note that your child's chart will be accessed through your (the proxy's) MyChart record. Completing this form will establish a MyChart record for you (if you don't have one) and proxy access to your child's chart.

Authority of Proxy:

Patient is a minor and I am the patient's parent and natural guardian. My rights to seek medical information on the minor patient have not been limited by court order.

Patient is a minor and I am the patient's guardian.

Other _____

MyChart Terms and Conditions

- 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 a 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. MyChart does not include medical information relating to diagnosis of mental illness, alcohol/drug abuse, sexually transmitted diseases, HIV, some communicable diseases, or pregnancy and childbirth. MyChart does not include physician notes. MyChart may include prescription medications and reason for provider visits past and future.
- 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 Altru Health System as a convenience to its patients and that Altru Health System 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 a MyChart proxy.

Proxy:

I acknowledge and agree that:

- Proxy access will be deactivated on the patient's 18th birthday.
- I will comply with the terms and conditions on the MyChart web page and this document.
- When my legal authority to act on behalf of my child has been inactivated, revoked, terminated or expired, I must immediately notify Altru Health System in writing of the revocation, termination or expiration and mail it to: Altru Health System, Attn: MyChart Medical Records 1200 South Columbia Road, P.O. Box 6002, Grand Forks, ND 58206-6002

MyChart PEDIATRIC (AGE 0-17) PROXY ACCESS FORM

All fields required:

Proxy #1 Information: Full Name (print): _____

DOB: ____/____/____ Last 4 digits of SSN(s): _____

Email: _____ Phone: _____

Address: _____

Proxy #2 Information: Full Name (print): _____

DOB: ____/____/____ Last 4 digits of SSN(s): _____

Email: _____ Phone: _____

Address: _____

By **signing and dating** this Proxy Access Form, I am indicating I have read and accept the MyChart terms and conditions in this document.

Proxy #1 Signature Relationship to Patient Date (mm/dd/yyyy)

Proxy #2 Signature Relationship to Patient Date (mm/dd/yyyy)

PLEASE LEAVE FORM WITH OFFICE STAFF, OTHERWISE RETURN FORM TO:

LANGDON PRAIRIE HEALTH
ATTN: MyChart MEDICAL RECORDS
909 2ND STREET
LANGDON, ND 58249
PHONE: 701-256-6240