



MYCHART PROXY ACCESS FORM – MINOR
Parental or Legal Guardianship Proxy Access to
Hoag Clinic MyChart of a Minor Patient

To request proxy access to medical information that is made available through MyChart of a minor, please complete this form. Please note that the patient's chart will be accessed through your (the proxy's) MyChart, and the following age range limitations apply:

- Age 0-11: You will be granted full access to the minor's MyChart record.
- Age 12-17: You will be granted limited access to the minor's MyChart record unless the minor authorizes full access by signing this form.
- Age 18: You will no longer have access to the minor's MyChart record.

Patient Information: (Completion of all sections required - please print clearly)

Medical Record Number: _____

Patient's Name (last, first, middle initial): _____

Date of Birth: _____

Phone: _____

Email Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Proxy (Parent/Legal Guardian) Information:

In order to view the Minor's ("Patient's") information, the Proxy must also obtain their own MyChart account.

Proxy's Name: _____ Date of Birth: _____

Phone: _____

Email Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

My Relationship to the Minor is as follows (select one):

- Birth Parent
- Adoptive Parent
- Other: list _____
- Legal Guardian - Must attach a copy of the Court Order Appointing Guardian and Letters of Guardianship verifying the Proxy status as permanent legal guardian of the patient.





Terms and Conditions for Granting/Receiving Proxy Access

1. I have read, understand and agree to the requirements and procedures for accessing medical information through the MyChart application as provided in the MyChart Terms and Conditions of Use which can be obtained online at <https://www.hoagconnect.org/MyChart/Authentication/Login?mode=stdfile&option=termsandconditions>.
2. I understand that by granting proxy access, I am allowing the proxy access to the contents of my MyChart record. I understand that granting proxy access is completely voluntary.
3. If I am a minor child, age 12-17, I understand that by signing this consent form above I am granting my parent/legal guardian access to my medical information, including but not limited to: medications, past and future appointments, all messages to and from my provider(s), lab and radiology test results, immunizations and billing information.
4. I understand that the medical information included in MyChart may include medical information considered very personal, including information about sexually transmitted and other communicable diseases, drug and alcohol abuse, HIV/AIDS, and mental health services. My health care provider, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5. I understand that access to MyChart is provided as a convenience to patients and that Hoag Clinic has the right to deactivate my access or my proxy's access at any time for any reason or for no reason.
6. I understand that this authorization will continue until revoked. I understand that I may revoke this consent at any time in MyChart or may contact my clinic to have a proxy's access revoked.
7. I understand that it is my responsibility to terminate my proxy's access to my MyChart account if I no longer wish to allow him/her access to my MyChart information. Termination of proxy access is not immediate. Hoag will use its best efforts to terminate your proxy's access within ten (10) business days of receiving a written request.
8. I understand this consent will remain in effect until revoked in writing. If I am a minor child age 12-17, consent will expire at age 18.
9. If the minor patient is 11 years of age or younger, as proxy I must have parental rights or permanent legal guardianship rights to access this Minor's record. If my legal status changes, I will notify Hoag.
10. As proxy I have not been denied periods of physical placement with the minor and there are no court orders or restraining orders in effect limiting my access to this minor's medical records and/or information.
11. I understand that for all medical emergencies, I need to immediately dial 911.
12. I authorize the Use or Disclosure of Electronic Protected Health Information.

By signing below, I acknowledge that I have read, understand and agree to this MyChart Minor Proxy Access form, the terms and conditions for MyChart.

Signature of Patient: _____ Date/Time: _____
(Required for minor patients age 12 and older if full access is requested)

Signature of Parent/Legal Guardian (or authorized person): _____ Date/Time: _____

If signed by other than patient, indicate relationship: _____

Print Name (Legal Representative): _____

Please allow 5-10 business days for processing. You or your proxy will receive a letter with the access code. The access code will be valid for 14 days. You will need the access code to log into the account. It should not be shared with anyone.

Processed by: _____ Date: _____ Time: _____