MyChart **Child proxy form**

Access to your child's *MyChart* record

To sign up for access to your child's *MyChart* record, please complete both pages of this child proxy form and return it to the address shown below. Please note that your child's chart will be accessed through your *MyChart* record. Completing this form will establish a *MyChart* record for you and for your child.

Return all forms to: *MyChart* Services or fax (612) 262-1424
Mail Route 10607, 2925 Chicago Avenue, Minneapolis, MN 55407

Parent/guardian information: (all sections required – please print clearly)

Name (*last, first, middle initial*) _____

Last 4 digits SSN: _____ Date of birth: _____

Street address: _____ City:_____ State: _____ Zip: _____

E-mail address: _____ Phone number: _____

Check the box next to the organization that provides your primary care (select one): ☐ Allina Health
☐ FirstLight Health System ☐ Hutchinson Medical Center ☐ Grand Itasca Clinic & Hospital
☐ Regina Medical Center ☐ United Family Medicine

Please note the following age range limitations for *MyChart*. These age range limitations do not affect any legal right you have to access your child's record by other means. To request a paper copy of your child's record, contact your child's primary care clinic.

- **Age 0-12:** you will be granted full access to your child's *MyChart* record.
- **Age 13-17:** you will be granted partial access to your child's *MyChart* record. (appointment scheduling, immunizations)
- **Age 18:** you will no longer have access to your child's *MyChart* record.

Please provide the following information for each child:
All fields are required. If you have more than four children for whom you would like proxy access, please request another form or print one from https://mychartweb.com.

A. Name *(last, first, middle initial)*: _____
Last 4 digits SSN: _____ Date of birth: _____
Check the box next to the organization that provides your primary care (select one): ☐ Allina Health
☐ FirstLight Health System ☐ Hutchinson Medical Center ☐ Grand Itasca Clinic & Hospital
☐ Regina Medical Center ☐ United Family Medicine

B. Name *(last, first, middle initial)*: _____
Last 4 digits SSN: _____ Date of birth: _____
Check the box next to the organization that provides your primary care (select one): ☐ Allina Health
☐ FirstLight Health System ☐ Hutchinson Medical Center ☐ Grand Itasca Clinic & Hospital
☐ Regina Medical Center ☐ United Family Medicine

C. Name *(last, first, middle initial)*: _____
Last 4 digits SSN: _____ Date of birth: _____
Check the box next to the organization that provides your primary care (select one): ☐ Allina Health
☐ FirstLight Health System ☐ Hutchinson Medical Center ☐ Grand Itasca Clinic & Hospital
☐ Regina Medical Center ☐ United Family Medicine

Name *(last, first, middle initial)*: _____
Last 4 digits SSN: _____ Date of birth: _____
Check the box next to the organization that provides your primary care (select one): ☐ Allina Health
☐ FirstLight Health System ☐ Hutchinson Medical Center ☐ Grand Itasca Clinic & Hospital
☐ Regina Medical Center ☐ United Family Medicine

►**continued on page 2 – parent/guardian signature required**

MyChart terms and agreement

- 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 confidentiality may have been compromised in any way.
- I understand that it is my responsibility to ensure that my e-mail address is current at all times, and that if my e-mail address is not current I will not receive important messages from *MyChart*.
- 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 medical record may be requested from the patient's clinic.
- I understand that my activities within *MyChart* may be tracked electronically and that entries I make may become part of the medical record.
- I understand that access to *MyChart* is provided as a convenience to patients and that *MyChart* Services has the right to end access to *MyChart* at any time, for any reason.
- I understand that my use of *MyChart* is voluntary and I am not required to use *MyChart* or to authorize a *MyChart* proxy

Signature of parent/guardian **Relationship to patient** **Date** *(required)*

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