MyChart Teen Proxy Form

Access to Your Teen's MyChart Record

To sign up for access to your child's MyChart record, please complete both pages of this Teen Proxy Form and return it to the address shown below. Please note that your child's chart will be accessed through your MyChart record.

Return all forms to: Muskingum Valley Health Centers
C/o Information Technologies
716 Adair Ave.
Zanesville, OH 43701

Parent/Guardian Information: *(All sections required – please print clearly.)*

Name (*last, first, middle initial*) _____Social Security Number:_____Date of Birth_____
Street Address: _____City:_____State: _____ Zip: _____
Phone Number: _____ Email Address: _____Physician: _____

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.

- Once your child reaches **age 18 (the age of majority in Ohio) or is determined by your physician to be emancipated,** you will no longer have access to your child's MyChart record unless the child completes the Adult Proxy Form.

NOTE* While there is no statute specifically for emancipated minors in Ohio, your physician may determine emancipation if the minor is married, entered the armed services of the United States, become employed and self-subsisting, or has otherwise become independent from the care and control of a parent, guardian or custodian.

Please provide the following information for each child cared for in this office: (All fields are required. If you have more than four children for whom you would like proxy access, please request another form from the physician's office)

A. Name *(last, first, middle initial)*: _____
Social Security Number: _____Date of Birth: _____
Physician/Pediatrician:_____

B. Name *(last, first, middle initial)*: _____
Social Security Number: _____Date of Birth: _____
Physician/Pediatrician:_____

C. Name *(last, first, middle initial)*: _____
Social Security Number: _____Date of Birth: _____
Physician/Pediatrician: _____

D. Name *(last, first, middle initial)*: _____
Social Security Number: _____Date of Birth: _____
Physician/Pediatrician:_____

► ***Please remember to***

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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 teen's health information, and 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. I also understand that a paper copy of a patient's medical record may be requested from my physician's office.
- I understand that my activities within MyChart may be tracked by computer audit and that entries I make may become part of the medical record.
- I understand that Genesis HealthCare System and my physician's office/organization as a convenience provides access to MyChart to its patients and that Genesis HealthCare System and my physician's office/organization have 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.
- By signing below, I acknowledge that I have read and understand this MyChart Child Proxy Form and I agree to its terms.

Signature of Patient **Date** *(Required)*

NOTICE REGARDING DRUG/ALCOHOL AND MENTAL HEALTH

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTECTED BY FEDERAL CONFIDENTIALITY RULES (42 CFR, PART 2). THE FEDERAL RULES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN AUTHORIZATION OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR, PART 2. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. THE FEDERAL RULES RESTRICT ANY USE OF THE INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE PATIENT. YOUR PHYSICIAN MAY DETERMINE MENTAL HEALTH/PSYCHIATRIC OR ANY SENSITIVE DIAGNOSIS MAY NOT BE VIEWED ELECTRONICALLY.

For Office Use Only:
Information Release Date: _____ Physician Name: _____
Name of staff member/department: _____