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

Patient/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: ________

Email address: ____________________ Phone number: ____________________

Check the box next to the organization that provides your primary care (select one):

☐ Allina Health ☐ Cuyuna Regional Medical Center ☐ FirstLight Health System
☐ Glencoe Regional Health Services ☐ Grand Itasca Clinic & Hospital ☐ Hutchinson Health
☐ River's Edge Hospital & Clinic ☐ Riverwood Healthcare Center ☐ St. Croix Regional Medical Center
☐ United Family Medicine ☐ The Urgency Room ☐ Western Wisconsin Health/Baldwin Area Medical Center

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 www.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 ☐ Cuyuna Regional Medical Center ☐ FirstLight Health System
☐ Glencoe Regional Health Services ☐ Grand Itasca Clinic & Hospital ☐ Hutchinson Health
☐ River's Edge Hospital & Clinic ☐ Riverwood Healthcare Center ☐ St. Croix Regional Medical Center
☐ United Family Medicine ☐ The Urgency Room ☐ Western Wisconsin Health/Baldwin Area Medical Center

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 ☐ Cuyuna Regional Medical Center ☐ FirstLight Health System
☐ Glencoe Regional Health Services ☐ Grand Itasca Clinic & Hospital ☐ Hutchinson Health
☐ River's Edge Hospital & Clinic ☐ Riverwood Healthcare Center ☐ St. Croix Regional Medical Center
☐ United Family Medicine ☐ The Urgency Room ☐ Western Wisconsin Health/Baldwin Area Medical Center

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 ☐ Cuyuna Regional Medical Center ☐ FirstLight Health System
☐ Glencoe Regional Health Services ☐ Grand Itasca Clinic & Hospital ☐ Hutchinson Health
☐ River's Edge Hospital & Clinic ☐ Riverwood Healthcare Center ☐ St. Croix Regional Medical Center
☐ United Family Medicine ☐ The Urgency Room ☐ Western Wisconsin Health/Baldwin Area Medical Center

D. 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 ☐ Cuyuna Regional Medical Center ☐ FirstLight Health System
☐ Glencoe Regional Health Services ☐ Grand Itasca Clinic & Hospital ☐ Hutchinson Health
☐ River's Edge Hospital & Clinic ☐ Riverwood Healthcare Center ☐ St. Croix Regional Medical Center
☐ United Family Medicine ☐ The Urgency Room ☐ Western Wisconsin Health/Baldwin Area Medical Center

▶ **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 health information. If I share my username 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 email address is current at all times, and that if my email 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 health record and that MyChart does not reflect the complete contents of the health record. I also understand that a paper copy of a patient's health record may be requested.
- 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 patient/authorized person	**Relationship to patient**	**Date** *(required)*

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