

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):

- | | | |
|------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Allina Health | <input type="checkbox"/> Baldwin Area Medical Center | <input type="checkbox"/> Cuyuna Regional Medical Center |
| <input type="checkbox"/> FirstLight Health System | <input type="checkbox"/> Glencoe Regional Health Services | <input type="checkbox"/> Grand Itasca Clinic & Hospital |
| <input type="checkbox"/> Hutchinson Health | <input type="checkbox"/> River's Edge Hospital & Clinic | <input type="checkbox"/> Riverwood Regional Medical Center |
| <input type="checkbox"/> St. Croix Regional Medical Center | <input type="checkbox"/> United Family Medicine | <input type="checkbox"/> The Urgency Room |

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:

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.allinahealth.org/proxy.

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):

- | | | |
|------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Allina Health | <input type="checkbox"/> Baldwin Area Medical Center | <input type="checkbox"/> Cuyuna Regional Medical Center |
| <input type="checkbox"/> FirstLight Health System | <input type="checkbox"/> Glencoe Regional Health Services | <input type="checkbox"/> Grand Itasca Clinic & Hospital |
| <input type="checkbox"/> Hutchinson Health | <input type="checkbox"/> River's Edge Hospital & Clinic | <input type="checkbox"/> Riverwood Regional Medical Center |
| <input type="checkbox"/> St. Croix Regional Medical Center | <input type="checkbox"/> United Family Medicine | <input type="checkbox"/> The Urgency Room |

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):

- | | | |
|-----------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Allina Health | <input checked="" type="checkbox"/> Baldwin Area Medical Center | <input checked="" type="checkbox"/> Cuyuna Regional Medical Center |
| <input checked="" type="checkbox"/> FirstLight Health System | <input checked="" type="checkbox"/> Glencoe Regional Health Services | <input checked="" type="checkbox"/> Grand Itasca Clinic & Hospital |
| <input checked="" type="checkbox"/> Hutchinson Health | <input checked="" type="checkbox"/> River's Edge Hospital & Clinic | <input checked="" type="checkbox"/> Riverwood Regional Medical Center |
| <input checked="" type="checkbox"/> St. Croix Regional Medical Center | <input checked="" type="checkbox"/> United Family Medicine | <input checked="" type="checkbox"/> The Urgency Room |

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):

- | | | |
|-----------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Allina Health | <input checked="" type="checkbox"/> Baldwin Area Medical Center | <input checked="" type="checkbox"/> Cuyuna Regional Medical Center |
| <input checked="" type="checkbox"/> FirstLight Health System | <input checked="" type="checkbox"/> Glencoe Regional Health Services | <input checked="" type="checkbox"/> Grand Itasca Clinic & Hospital |
| <input checked="" type="checkbox"/> Hutchinson Health | <input checked="" type="checkbox"/> River's Edge Hospital & Clinic | <input checked="" type="checkbox"/> Riverwood Regional Medical Center |
| <input checked="" type="checkbox"/> St. Croix Regional Medical Center | <input checked="" type="checkbox"/> United Family Medicine | <input checked="" type="checkbox"/> The Urgency Room |

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):

- | | | |
|-----------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Allina Health | <input checked="" type="checkbox"/> Baldwin Area Medical Center | <input checked="" type="checkbox"/> Cuyuna Regional Medical Center |
| <input checked="" type="checkbox"/> FirstLight Health System | <input checked="" type="checkbox"/> Glencoe Regional Health Services | <input checked="" type="checkbox"/> Grand Itasca Clinic & Hospital |
| <input checked="" type="checkbox"/> Hutchinson Health | <input checked="" type="checkbox"/> River's Edge Hospital & Clinic | <input checked="" type="checkbox"/> Riverwood Regional Medical Center |
| <input checked="" type="checkbox"/> St. Croix Regional Medical Center | <input checked="" type="checkbox"/> United Family Medicine | <input checked="" type="checkbox"/> The Urgency Room |

▶ 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)**