Atlantic Health System

DT2208

PATIENT ID HERE

CHILD PROXY FORM 0-11

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 (or fax) to your physician's office or the email 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. You must include a government issued ID*.

Return (or fax) all forms to your physician's office or email to MyChart.HIM@atlantichealth.org

PARENT/GUARDIAN INFORMATION: ***(All sections required - please print clearly)***

Name *(last, first, middle initial)*: _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Home Phone Number: _____

Have you received any services at Atlantic Health System? ☐ YES ☐ NO

Please note that this form should not be used in the case of an emancipated minor.[1] An emancipated minor should use the Adult Proxy Form. To request a paper copy of your child's record, contact the Health Information Management Department at Atlantic Health System. Below are the following age range limitations for MyChart.

- If your child is age 0-11, you will be granted full access to your child's MyChart record. Signed proxy authorization form is required. When child turns 12 years old, proxy access is automatically transitioned to Partial.
- If your child is age 12-17 you will be granted partial access to your child's MyChart record (e.g., immunizations and allergies). Signed proxy authorization form is required. When an adolescent minor Full Access proxy authorization form is completed and processed by your adolescent minor's doctor, you will be granted full access. Annual renewal for Full Access proxy is required. Expires on patient's birth date.
- Once your child turns 18, you will no longer have access to your child's MyChart record. An Adult Proxy authorization is required to continue Proxy access.

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.

A. Name *(last, first, middle initial)*: _____ Date of Birth: _____

Patient Address, if different from above: _____

B. Name *(last, first, middle initial)*: _____ Date of Birth: _____

Patient Address, if different from above: _____

C. Name *(last, first, middle initial)*: _____ Date of Birth: _____

Patient Address, if different from above: _____

D. Name *(last, first, middle initial)*: _____ Date of Birth: _____

Patient Address, if different from above: _____

PLEASE REMEMBER TO READ AND COMPLETE PAGE 2 OF THIS FORM

[1]In New Jersey, an "emancipated" minor is a person under the age of 18 who is: (a) married, (b) pregnant, (c) in U.S. military service, (d) declared emancipated by a court or administrative agency.

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Authority to Obtain a Child's Health Information (check one):

Check all that applies for each child:

- I am the child's birth parent with current custody: ☐ Child A ☐ Child B ☐ Child C ☐ Child D
- I have been awarded custody of the child with the right to make health care decisions (attach court order(s) showing custody/rights): ☐ Child A ☐ Child B ☐ Child C ☐ Child D

MyChart Terms and Agreement

- I understand that MyChart is intended as an online source of limited confidential medical information. If I share or allow my MyChart ID and password to be disclosed to another person, that person may be able to view health information about the above Patient and transmit that information to a third party.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to immediately 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 Patient's medical record. I also understand that a paper copy of a patient's complete medical record may be requested from the Health Information Management Department of Atlantic Health System.
- I understand that access to MyChart is provided by my physician's office/Atlantic Health System as a convenience to its patients and that my physician's office/Atlantic Health System has 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.
- I understand that while Atlantic Health System will use reasonable security efforts, no system can guard against all risks of intentional intrusion or inadvertent disclosure medical information on MyChart. MyChart transmits medical information over the internet, a medium that is beyond the control of Atlantic Health System and its contractors. I HEREBY EXPRESSLY ASSUME THE SOLE RISK OF ANY UNAUTHORIZED DISCLOSURE OR INTENTIONAL INTRUSION, OR OF ANY DELAY, FAILURE, INTERRUPTION OR CORRUPTION OF DATA OR OTHER INFORMATION TRANSMITTED RELATING TO THE USE OF THIS SERVICE.
- I understand that I will no longer have MyChart proxy access when my child reaches the age of 18 or upon the Atlantic Health System learning that my child has become emancipated. I also understand that federal and state law may protect the privacy of certain types of medical care sought by un emancipated minors on a confidential basis.
- MyChart allows patients and proxies the ability to use confidential messaging. You can elect to message a physician and prevent others from viewing the correspondence.
- You should not make any decision relating to your health based upon the information available in MyChart and/or in your medical record. You always should consult with your physician for health-related matters.
- **I have read, understand and agree to the terms and conditions set forth on this page, as well as the terms and conditions included on the webpage used to access MyChart** - https://mychart.atlantichealth.org/mychart/

Signature of Parent/Guardian: _____ Date: _____ Time: _____

Relationship to Patient: _____

*__Examples of ID:__ Government issued photo ID (e.g. driver's license, passport, non-driver ID).

*__Disclaimer:__ Incomplete email requests, without all ID requirements attached will not be processed. Must re-submit request with all attached ID requirements.

FOR OFFICE USE ONLY:

Name of Office Personnel who validated Proxy Access (please print):

Name: _____ Department: _____ Date: _____