Atlantic Health System

DT2208

PATIENT ID HERE

ADOLESCENT MINOR AUTHORIZATION FULL PROXY 12-17

Authorization Granting Access to MyChart Medical Record

In signing this form, you are agreeing that your Parent(s) or Guardian(s) or Person Seeking Access/Proxy can have full access to your electronic health information through MyChart patient portal application. "Proxy" is a person who is granted access to another individual's medical record. Proxy and the Patient must sign this form.

If you sign this form, you are agreeing that your Parent(s); Guardian(s) or Person Seeking Access/Proxy can look at your electronic health information through MyChart.

This form must be completed by the patient, parent/guardian, person seeking access/proxy and physician during the office visit.

I understand there is an electronic medical record with information about my medical care and treatment at Atlantic Health System, and from doctors who work with the hospital. I am aware that some of my medical information from this record can be looked at through a secure website called MyChart.

- I want to give my parent(s)/guardian(s) or person seeking access/proxy permission to use MyChart to look at my medical information, including information about my *past, current* and *future* care and treatment at Atlantic Health System and affiliated doctors and offices.

- I understand that this permission form may allow my parent(s)/guardian(s) or person seeking access/proxy to see all my health care information that is on MyChart, including information related to **PREGNANCY or BIRTH CONTROL, SEXUAL TRANSMITTED DISEASE (STD) TREATMENT (and other REPRODUCTIVE HEALTH CARE), ALCOHOL or DRUG ABUSE TREATMENT, GENETIC TESTING, MENTAL HEALTH CARE** and/or **HIV or AIDS** (HIV is short for Human Immunodeficiency Virus, the virus that causes AIDS). I understand that after my parent/guardian or person seeking access/proxy reviews my medical information, it could be disclosed to others and would no longer be protected by federal privacy regulations.

- I understand that MyChart allows for confidential messaging. I can choose to send messages to my doctors and select the option that prohibits my parents(s)/guardian(s) or person seeking access/proxy from having the ability to view the messages.

- I know that I do not have to sign this form or use MyChart, and I can still get treatment from Atlantic Health System and their doctors.

- I understand that I can request to have this access revoked at any time through my MyChart account. I understand that Atlantic Health System and my doctors can revoke access to MyChart (for patients or their proxies) at any time and for any reason.

- I had a chance to ask questions about this form. Any questions I had were answered. If I choose to give my permission now, I can change my mind and cancel this form later at any time.

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 Department at Atlantic Health System. Parents/Guardians/Person Seeking Access/Proxy 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 reaches age 18, you will no longer have access to your child's MyChart record.

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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Make sure you have read the information provided on page (1) before signing this form.

PATIENT 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: _____

PARENT(S)/GUARDIAN INFORMATION(S) OR PERSON SEEKING ACCESS/PROXY INFORMATION: ***(Who will be given access to your MyChart)***

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

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

Email Address: _____ Home Phone Number: _____

REASON FOR RELEASE OF INFORMATION: Parent(s) or Guardian(s) or Person seeking access/proxy to MyChart.

By signing this form, I assent that the individual I have listed above can have access to my medical information in MyChart.

MyChart Terms and Agreement

- I understand that MyChart is intended to provide limited access to 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 my health information, and information about someone who has authorized me as a MyChart proxy 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 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 the Health Information Department of Atlantic Health System.
- I understand that access to MyChart is provided by Atlantic Health System as a convenience to its patients and that 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 this form authorizes Atlantic Health System to provide my medical information, which may include *Pregnancy, STD Treatment, Reproductive Health Care, Alcohol/Drug Abuse Treatment, Genetic Testing, Mental Health or HIV-related information*, via MyChart to the designated proxy listed above.
- 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.

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- 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 Patient: _____ Date: _____ Time: _____

Signature of Parent/Guardian: _____ Date: _____ Time: _____
(or person seeking access/proxy)

FOR OFFICE USE ONLY:

Name of Provider who validated Proxy Access (please print):

Physician Name: _____ Department: _____

Physician Signature: _____ Date: _____ Time: _____