

Palos MyChart Patient Portal

Proxy Authorization for Ages 12 - 17

This form must be completed by the 12 – 17 year old patient to provide the parent(s)/legal guardian and patient access to the Palos MyChart Patient Portal account of the 12 – 17 year old patient. Access to account will be terminated in the event parental rights or legal guardianship is terminated.

Parent/Guardian Information (All sections required-please print clearly.)

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address on file: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Record # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Information (All fields are required. A separate form must be completed for each minor.)

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the patient’s address is the same as that provided for the parent/guardian above, please check here:

If the patient’s address is different from that provided for the parent/guardian above, please complete below:

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Record # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am requesting that the proxy listed above receive access to my health information that is available in the Palos MyChart Patient Portal. I authorize the follow access be granted (please check one):

□ Full access (proxy can see/do everything that patient can do in their own MyChart account)

□ Parent to Teen access (view insurance information and update demographics)

I authorize release of this information only through the Palos MyChart Patient Portal. This form does not authorize release of my medical record to my designated proxy by other methods or in other forms (e.g. paper).

By signing below, I acknowledge that I have read and understand this Proxy Authorization. I also certify that I am the patient listed on this form and that all information I have provided is correct.

I understand that my access will be automatically terminated on my child’s 18th birthday.

Signature of Patient\* Date (Required)

Witness Signature (Required) Date (Required)

\*If the individual indicates that he or she is the child’s legal guardian, this request must be accompanied by a copy of legal documentation verifying the individual’s status as a legal guardian.