

Palos MyChart Patient Portal

Minor Proxy Authorization

(under age 12)

This form must be completed to provide the parent(s) or legal guardian(s) access to the Palos MyChart Patient Portal account of their minor child under age 12. Each parent or legal guardian requesting access must have a Palos MyChart Patient Portal account. Access to account will be terminated in the event parental rights or legal guardianship is terminated or upon the child reaching age 12.

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 # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP OF PROXY TO PATIENT

□ Parent

□ Legal Guardian (additional documentation may be required)

□ Power of Attorney (additional documentation may be required)

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

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

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

If the minor’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 I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as the parent/guardian of the above-identified patient, receive access to this patient’s health information that is available in the Palos MyChart Patient Portal. This form does not authorize release of the minor patient’s medical record to me by other methods or in other forms (e.g. paper).

By signing below, I acknowledge that I have read and understand this Minor Proxy authorization. I also certify that I am the parent or legal guardian of the minor listed on this form and that all information and any supporting documentation that I have provided is correct.

I understand that my access will be automatically terminated on my child’s 12th birthday.

Signature of Parent/Guardian\* Relationship to Patient 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.