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.

Return this form: to the Records Pick-up Window at Palos Hospital, please bring ID for verification.
Palos Hospital Address: 12251 S. 80th Ave, Palos Heights (Enter through main entrance)
For additional questions, the Release of Information Staff may be contacted at 708-923-8660.

Name _____ Date of Birth _____

Email address on file: _____

Street Address _____ City _____ State ____ Zip _____

Phone Number _____ Social Security # _____

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 _____

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.