Trinity Health Of New England | Medical Group

Proxy Form for Access to Minor Child's Information (use for minors 0-11 years)

Access to Your Minor Child's MyChart Record

This form may be used by the personal representative of an unemancipated minor child, meaning the parent, legal guardian, or other person acting in the place of the parent with legal authority to make health care decisions on behalf of the unemancipated minor child. Please note that Trinity Health Of New England Medical Group, in its sole discretion and in accordance with applicable law, may refuse a personal representative's request to access a minor child's health information if Trinity Health Of New England Medical Group determines it would not be in the best interests of the minor child.

Trinity Health Of New England Medical Group is pleased to offer you information, including access to of your minor child's health information, via a Web-based version of our computer system called MyChart (the "Site").

Although MyChart is extremely helpful, it's important to note that your child's entire Trinity Health Of New England Medical Group medical record information will not be accessible through the Site. Please refer to
Trinity Health Of New England Medical Group's Notice of Privacy Practices for a description of how to obtain a copy of your minor child's Trinity Health Of New England Medical Group medical record.

In addition, under state and federal law, there are certain types of health information that the parent or other legal representative of a minor patient age 12 or older may not view without consent of the minor patient; due to these restrictions, parents and legal representatives of minor children seeking proxy access to the information of a minor child age 12 or older will obtain only limited access to information available through the Site. Thus, when a minor patient reaches age 12, access restrictions applicable to the parent/legal representative will be placed on the patient's MyChart Account until the minor child reaches age 18, at which time access to the patient's MyChart Account by the parent or legal representative will terminate completely.

To request access to your minor child's medical record information please complete the next two pages and return the completed forms to one of our Pediatric receptionists or medical assistants. Please note that in order to process your proxy request proper identification will be required.

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Proxy Form for Access to Minor Child's Information

Trinity Health Of New England Medical Group is pleased to offer you access to your personal health record via a Web-based version of our computer system called MyChart (the "Site").

Please note that not all of your Trinity Health Of New England Medical Group medical record information will be accessible through the Site. Please refer to Trinity Health Of New England Medical Group's Notice of Privacy Practices for a description of how to obtain a copy of your Trinity Health Of New England Medical Group medical record.

****** Please email this completed form to: mychartsupport@riverbendmedical.com**

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

Parent/Guardian Name (*last, first, middle initial*) _____

_____

Parent's/Guardian's Date of Birth: _____

☐ If you have a MyChart account, please provide the last 4 digits of your Social Security #: _____

☐ If you do NOT have a MyChart account, please provide your Social Security #: _____-_____-_____

Street Address: _____ City: _____

State: ___ Zip: _____ Phone Number: _____

Email Address: _____

Please indicate basis of legal authority to act on behalf of minor child for health care:

☐ Parent

☐ Legal Guardian *(copy of legal documentation must be supplied)*

☐ Other: _____ *(copy of legal documentation must be supplied)*

Office Use Only

☐ Verified ID Location _____ Employee _____

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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, or print the form from: www.riverbendmedical.com/mychart).

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

Date of Birth: _____ PCP: _____

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

Date of Birth: _____ PCP: _____

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

Date of Birth: _____ PCP: _____

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

Date of Birth: _____ PCP: _____

Parent/Guardian signature is required

Agreement and Acknowledgement

- I understand that the Site is intended as a secure online source of confidential medical information. 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 the Site contains selected, limited medical information from my child's medical record and that the Site does not reflect the complete contents of the Trinity Health Of New England Medical Group medical record. I also understand that a copy of my child's medical record may be requested from Trinity Health Of New England Medical Group's Health Information Management Department.
- I understand that my activities within the Site may be tracked by computer audit and that entries I make may become part of my child's medical record.
- I understand that access to the Site is provided by Trinity Health Of New England Medical Group as a convenience to its patients and their legal representatives and that Trinity Health Of New England Medical Group has the right to deactivate my access to the Site at any time for any reason. I understand that use of the Site is voluntary, and I am not required to use the Site.
- I acknowledge receipt of, and agree to comply with, all Terms and Conditions applicable to the Site, as attached hereto,
- By signing below, I acknowledge that I have read and understand this Proxy Form and the Terms and Conditions, and I agree to all terms.

I certify that I am the legally authorized representative of the above-named patient(s), with legal authority to make health care decisions on behalf of the above-named patient(s), and all information I have provided above is correct.

▶ _____ / / _____

Signature of Parent/Legal Representative **Relationship to Patient** **Date** *(Required)*