Authorization for Teen Proxy - Full Access

If you would like to send a message/ask a question about MyChart Proxy without submitting a request for proxy access, please call **1.855.222.3648** to talk to MyChart staff.

This authorization form (the "Authorization") should be used when a parent or guardian wishes to authorize Riverview Health, including its affiliates, subsidiaries, and its affiliated hospitals, facilities, labs, and providers ("Riverview") to allow a minor between the ages of 14 and 17 to have grant full proxy access to his/her parent/ guardian and have access to his/her protected health information contained therein. For purposes of this Authorization, the minor named below is referred to as the "Patient" or "Teen Patient".

- Parent/ Guardian Name: _____
- Parent/ Guardian Date of Birth: _____
- Parent/ Guardian Street Address: _____
- Parent/ Guardian City: _____
- Parent/ Guardian State: _____
- Parent/ Guardian ZIP: _____
- Parent/ Guardian Social Security Number (last 4): _____
- Parent/ Guardian Email Address: _____

Note: To receive a link via email, provide the teen's email address. The email address provided cannot be a parent/guardian email address or an email address associated with another MyChart account.

The purpose of this Authorization is to provide the teen patient with access to those portions of his/her Riverview electronic health record that Riverview makes available to minors between the ages of 14 and 17 through MyChart and/or MyChart Bedside. Accordingly, I authorize Riverview to disclose to the above Teen patient all information from the patient's health records that can be made available to the patient through the MyChart portal and MyChart Bedside application which may include, but is not limited to, lab and other test results, medications, summary of medical problems and history, and other information concerning the patient's treatment and health.

This Authorization and the access to the health records through MyChart and MyChart Bedside shall remain in effect until I revoke this Authorization. Notwithstanding the foregoing, I understand that my authorization will not be required when the teen patient reaches the age of eighteen or authorization is otherwise not required by law.

This Authorization is voluntary. I understand that I may revoke it at any time, except to the extent that action has already been taken in reliance upon it. To revoke it, I will send a signed and dated letter via email to **HIM@riverview.org** that includes:

- Date: _____
- Statement requesting revocation of Teen Patient access to MyChart account: _____
- Parent/ guardian signature: _____

Note: Email transactions are not encrypted and may be viewed by a third party.

If I do not sign this form or if I later revoke my authorization, it will not affect any treatment, payment, or enrollment or eligibility for benefits which the Patient is eligible to receive from Riverview.

☑ I confirm that I have had the opportunity to read and consider the contents of this Authorization, and I agree to be bound by them. I release Riverview from any legal responsibility or liability for providing MyChart and MyChart Bedside access to the Teen Patient listed above. I understand that the Teen Patient may redisclose or otherwise not keep the health information he/she receives confidential and that it may no longer be protected by federal state privacy laws. I understand that MyChart account holders may give third parties access to portions of their health record using MyChart's Share Everywhere. I authorize the Teen Patient's use of Share Everywhere and Riverview to grant third party access as initiated by the Teen Patient. If executing this Authorization by electronic signature, I consent to the use of electronic records and authorize the disclosures set forth above.

- Parent/ Guardian Name: _____
- Parent/ Guardian Relationship to Patient: _____
- Date of Signature: _____

Signature