CHS MyChart Child Proxy Authorization

This form must be completed for a parent or legal guardian to obtain access to a child's CHS MyChart account. Once completed, CHS MyChart accounts will be created for both the child and the parent/guardian. The parent/guardian will have access to the child's CHS MyChart account through his/her own CHS MyChart account. *Documentation demonstrating a guardian's legal authority must be attached to this form.*

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

Name	**Date of Birth:** / /
Address:	
ID Number:	

Child's Information (All sections required — please print clearly.)

Name	
Address:	**Date of Birth:** / /
Medical Record Number:	

I understand that CHS MyChart is a secure online source of protected health information. Anyone I share my user ID and password with will have access to my CHS MyChart record and all of the protected health information concerning my child and anyone else who has authorized me as a CHS MyChart proxy. I understand that once any health information is disclosed, the other person may re-disclose the health information about me seen in CHS MyChart. This re-disclosure may not be covered by federal privacy protections.

I understand that it is my responsibility to select a confidential password, maintain it and change it if I feel that it has been compromised.

CHS MyChart is provided by your Provider and Catholic Health Services of Long Island (CHS) as a convenience to patients. I understand that once my child reaches the age of 18, the age of majority under the law, or becomes an emancipated minor, my access to his/her account will be terminated, unless my child grants me continued access.

I understand that my Provider and/or CHS have the right to deactivate my account at any time and for any reason. I understand that my participation in CHS MyChart is voluntary and is not a condition of my health care treatment, payment or other services.

If applicable, the documentation I submitted to establish my legal guardianship is true and accurate. If my legal authority to act on behalf of the child is inactivated, revoked, terminated or expires, I agree to notify the Provider immediately in writing. My access to the child's CHS MyChart record will end.

I request access as a proxy to my child's Protected Health Information through CHS MyChart. I acknowledge that I have read and understand this authorization, and I agree to abide by its terms.

X _____ / _____ /

Parent/Guardian Signature *(required)* **Relationship to Patient** **Date**