Mercyhealth™
A passion for making lives better.™

Minor Proxy Request Form

Access to a minors *Mercy MyChart* record
To request access to the *Mercy MyChart* account of a minor whose medical care you manage, please complete this form. Access will automatically terminate at the time the minor reaches age 18.

Return form to: *MyChart* Support
1236 Barberry Dr.
Janesville WI 53546
888-99MYCHART or 888-996-9242
Fax # 608-314-8722

Please print clearly:

Proxy information (Person requesting access)

Name of Proxy _____ Date of Birth: ____/____/_____
(*Last, first, middle initial*)
Street Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone Number: _____

Relationship to patient:
☐ Parent ☐ Legal Guardian ** ☐ Other (specify) _____

Child's Information:

A. Name _____ Date of Birth: ____/____/_____
(*Last, first, middle initial*)

B. Name _____ Date of Birth: ____/____/_____
(*Last, first, middle initial*)

C. Name _____ Date of Birth: ____/____/_____
(*Last, first, middle initial*)

MyChart terms and agreement

- I understand that *Mercy MyChart* is intended as a secure online source of medical information containing a limited amount of information obtained from the electronic medical record and may include information from all Mercy Health System facilities. This may include information about mental health, development disabilities, alcohol and/or drug abuse, acquired humane deficiency syndrome (AIDS), HIV test results and/or intoxication tests.
- I understand that access to *Mercy MyChart* is provided as a convenience to patients and *Mercy Health System* has the right to end access to *Mercy MyChart* at any time.
- I understand that once information has been disclosed, it potentially may be re-disclosed by the proxy and the disclosed information may not be covered by federal privacy protections.
- I understand that designating a *Mercy MyChart* proxy is voluntary. I am not required to designate a *Mercy MyChart* proxy and I am not required to provide this authorization. I also understand that Mercy Health System does not condition any of my healthcare treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.
- I understand this authorization is valid until I revoke in writing to Mercy Health System or the child listed above reaches the age of 18 and I will no longer have access to the child's *Mercy MyChart* account.
- I understand my revocations will not affect any disclosures that were made prior to processing the revocation.

I acknowledge that I have read and understand this *Mercy MyChart* Minor Proxy Request Form and agree to its terms.

➔ _____
Signature of Proxy *Relationship to patient* *Date (required)*

** Please provide a copy of legal paperwork verifying this information if not already on file