OMC MyChart Minor Proxy Access

Parental or Legal Guardianship Access to OMC MyChart of a Minor Patient

To request proxy access to medical information that is made available through OMC MyChart of a minor, please complete this form. Please note that the patient's chart will be accessed through your (the proxy's) OMC MyChart, and the following age range limitations apply:

- *Age 0-12: You will be granted full access to the Minor's OMC MyChart record.*
- *Age 13-17: You will be granted limited access to the Minor's OMC MyChart record. To obtain full access, the minor and the proxy will need to complete the OMC MyChart Teen Full Proxy Access form and the OMC MyChart Teen Authorization for Release of Health Information form. If the minor is unable to complete the forms, please contact Olmsted Medical Center's information privacy specialist at 507.287.2776.*
- *Age 18: You will no longer have access to the minor's OMC MyChart record.*

Patient Information (All sections required – please print clearly.)

Patient Name: _____ **E-mail:** _____

Address: _____ **Apt #:** _____
(Street)

_____ **Date of Birth**: _____ **Phone:** _____
(City, State, Zip)

Proxy Information (All sections required – please print clearly.)

Proxy Name: _____ **E-mail:** _____

Address: _____ **Apt #:** _____
(Street)

_____ **Date of Birth**: _____ **Phone:** _____
(City, State, Zip)

My relationship to the Minor is:

❑ Birth Parent ❑ Adoptive Parent ❑ Other: list _____

OR

❑ Legal Guardian – Must attach a copy of the Court Order appointing guardianship.

OMC MyChart Terms and Conditions of Use

I have read and understand the requirements and procedures for accessing medical information through the OMC MyChart application as provided in the OMC MyChart Terms and Conditions of Use which can be obtained at any Olmsted Medical Center location or online at https://www.olmmed.org.

I acknowledge that I have read and understand this OMC MyChart Minor Proxy Access form, and I agree to be the OMC MyChart proxy for the patient named above.

_____ _____/_____/_____
Signature of Parent or Legal Guardian Date of Signature

_____ _____
Printed Name of Parent or Legal Guardian Relationship to Patient or Description of Legal Authority
(Documentation of legal authority required - please submit.)

Submit completed form to Olmsted Medical Center, Attn: Information Privacy Specialist, 210 Ninth Street SE, Rochester, MN 55904.