OMC MyChart Teen Full Proxy Access

Parental or Legal Guardianship Full Access to OMC MyChart of a Patient 13 to 17 Years Old

To request full proxy access to medical information that is made available through OMC MyChart of a minor between the age of 13 and 17, please complete this form. The patient must sign this form, agreeing to allow parental or legal guardianship access. Please note that the patient's chart will be accessed through your (the proxy's) OMC MyChart.

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)

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 Teen Full Proxy Access form, and I choose to designate the person named above as my OMC MyChart proxy.

____   _______/__________/__________
Signature of Patient (teen age 13-17 years old)   Date of Signature

____   _______/__________/__________
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.

OMC MyChart Teen Authorization for Release of Health Information

For OMC Staff Use Only:

Patient MRN: ___________________

Proxy Create Date/By: ____________

Patient Name: ____

Address: ____ **Apt #:** ____________________
(Street)

___________________________________ **Date of Birth**: ______________ **Phone:** ________________
(City, State, Zip)

I authorize Olmsted Medical Center to release my health information contained in my OMC MyChart record to my designated proxy, ___________________________________ *(insert name of proxy)* via OMC MyChart. This authorization form does not allow the release of information to my designated proxy by other methods or in other forms. I understand this information may include records related to evaluation or treatment of behavioral or mental health, alcohol and drug abuse, and HIV/AIDS.

This authorization is valid for two years from the date signed or on a different time period provided by law or on the date/event specified here: ____.

I understand I have the right to revoke my authorization at any time. I understand that if I revoke this authorization, I must do so by completing OMC's *Revocation of Authorization to Disclose Health Information* form or by sending my revocation request in writing to Olmsted Medical Center, Attn: Information Privacy Specialist, 210 Ninth Street SE, Rochester, MN 55904. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that if I revoke this authorization, my designated proxy's access to my OMC MyChart record will be deactivated.

I understand designating an OMC MyChart proxy is completely voluntary. I understand that I am not required to designate a proxy and I am not required to provide this authorization. If I do not provide this authorization, I understand that OMC is not permitted to provide my designated proxy access to my health information via OMC MyChart. I understand any release of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I may contact OMC's information privacy officer. I understand OMC will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand this is a legal document and by signing, I agree that I understand and accept the terms on this form.

____   _______/__________/__________
Signature of Patient (teen age 13-17 years old)   Date of Signature

____   _______/__________/__________
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