St. Charles HEALTH SYSTEM

MYCHART ACCESS AUTHORIZATION WITH MINOR PROXY

for SCHS Patients and it's Community Connect Affiliates

Minor / Child Information

Complete one authorization per minor child less than 18 years of age.
All fields are required.

Patient Name:_____ ☐ Male ☐ Female

Relationship to Parent / Guardian:_____ DOB: _____ Age: _____

Parent / Guardian information

All fields are required.

Parent / Guardian Name:_____ DOB:_____

Address: _____ Email Address:_____

City, State, Zip: _____ Phone Number: _____

MyChart Terms and Conditions

I understand the following:

- MyChart contains selected, limited medical information from a patient's medical record and does not reflect the complete contents of the medical record. A paper copy or PDF of a patient's medical record may be requested from the patient's health care provider.
- My activities within MyChart are tracked by computer audit, and entries I make can become part of my medical record or my minor child's medical record.
- My access to certain information about my minor child will be terminated upon my minor child's fourteenth birthday in accordance with Oregon state law. At this time, my teen minor will also be eligible to activate his / her own MyChart account.
- If my teen minor has special health care needs, my child's provider may authorize full access to his / her MyChart account if considered to be in his / her best interest. My teen minor may also authorize my full access to his / her MyChart account after discussion of privacy rights with his/her provider.
- A reminder regarding any changes to my teen minor's MyChart account will be sent via message to the email listed on the proxy account 30 days in advance of the change. I understand I will receive the email notification and then will need to login to view the message.
- I agree to abide by the St. Charles Health System MyChart Terms and Conditions.
- **Send form to:** SCHS HIM Manager, at 2500 NE Neff Road, Bend, OR 97701

Parent / Guardian signature:_____ Date:_____

Parent / Guardian printed name:_____

If minor is between 14 and 17 years old, minor must acknowledge parent / guardian request for proxy access. If the minor has questions as to what information is viewable, please call 541-706-2752.

Minor signature (14 to 17 yrs only):_____ Date:_____

Minor printed name:_____

For Office Use Only

Document to be retained in Patient Record

Patient MRN:_____ Proxy Activation Date: _____

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