CHILD UNDER 12 PROXY REQUEST FORM

This form to be completed by a parent or legal guardian ("Proxy") who wants access to portions of his/her under 12 year old child's electronic protected health information ("ePHI") maintained at the Medical College of Wisconsin and/or Froedtert Health affiliates: Froedtert Hospital, Community Memorial Hospital, St. Joseph's Hospital, Froedtert & Medical College of Wisconsin Community Physicians, West Bend Surgery Center or Froedtert Surgery Center (the "Organizations") through MyChart. There is no access to a child's MyChart account for a child aged 12 - 17 years old.

Proxy makes sure all fields are completed and shows photo ID and legal documents (if Permanent Legal Guardian of the Patient) in clinic when submitting forms.

Child's ("Patient") Information:

Patient's Name:		DOB:	
Address:			
Phone Number:		Last 4 SSN:	

Parent/Legal Guardian ("Proxy") Information: **If the Proxy sees providers at the Organizations, the Proxy also needs to complete the Enrollment Form if not already completed.**

Email Address:					
Proxy's Name:		Proxy's DOB:		Phone #:	
Street Address:					
City:		State:		Zip:	

My Relationship to the Child is as follows:

☐ **Parent**

OR

☐ **Permanent Legal Guardian of the Patient** – Must attach a copy of the Court Order Appointing Guardian and Letters of Guardianship verifying the Proxy's status as permanent legal guardian of the patient.

By signing below, I acknowledge and agree that:

- I will be using my own MyChart account at the Organizations to access the Child's MyChart account.
- I will comply with the terms and conditions on the MyChart web page (located at http://www.mychartlink.com, then select the Terms and Conditions link on the page) and this document.
- I will keep my password confidential and not share this information with anyone.
- I must have parental rights or legal guardianship rights to access this Child's record.
- I have not been denied periods of physical placement with the Child and there are no court orders or restraining orders in effect limiting my access to this Child's medical records and/or information.
- Communications on behalf of the Child through MyChart must be sent from the Child's record and responses will be received in the Child's record. MyChart e-mail alerts will be sent to the e-mail address entered under Parent/Legal Guardian ("Proxy") Information.
- There are age range limitations for MyChart. These age range limitations do not affect any legal right I have to access the Child's record by other means. I can request a paper copy of the Child's record, by contacting the Health Information Management Department.
- For a child age 0 to 11 years, I will be granted full access to the Child's MyChart record. On the Child's 12th birthday, I will no longer have access to the Child's MyChart record.
- I have completed the MyChart Authorization for Use or Disclosure of Electronic Protected Health Information.

X_____/_____/_____/_____

Proxy Signature (Required) | Relationship to Patient (Required) | Date (Required) | Time (Required)

For Official Use:

1. I have given a photocopy of the signed MyChart Authorization document to the Patient.
2. I HAVE PLACED A PATIENT LABEL ON EACH OF THE PAGES GOING TO MEDICAL RECORDS.
3. I have viewed the Proxy's photo ID on _____ by _____

Date | Signature of MCW or Froedtert Health Staff

Medical Records Copy

Place Cadence Label Here

MyChart Authorization for Use or Disclosure of Electronic Protected Health Information - For Child Under 12 Proxy Request

Written authorization from the patient is required by law. By law, all items must be completed in order to process your request.

Patient's Name:		DOB:	
Address:			
Phone Number:		Last 4 SSN:	

- I authorize the use and/or disclosure of the patient's electronic protected health information ("ePHI") through MyChart as described below.
  - Names and addresses of Organizations authorized to release the ePHI through MyChart:
    - Froedtert Hospital, 9200 West Wisconsin Avenue, Milwaukee, WI 53226
    - Medical College of Wisconsin, 10000 Innovation Drive, Ste 300, Milwaukee, WI 53226
    - Community Memorial Hospital, W180 N8085 Town Hall Road, Menomonee Falls, WI 53051
    - St. Joseph's Hospital, 3200 Pleasant Valley Road, West Bend, WI 53095
    - Froedtert & Medical College of Wisconsin Community Physicians, 110 Lone Oak Lane, Hartford, WI 53027
    - West Bend Surgery Center, 1710 Vogt Drive, West Bend, WI 53095
    - Froedtert Surgery Center, 840 N. 87th Street, Milwaukee, WI 53226
  - Name and address of Person authorized to receive the ePHI through MyChart:

Proxy's Name:					
Street Address:					
City:		State:		Zip:	

  - Description of ePHI to be released through MyChart: Medical Record information available in MyChart
  - The ePHI is being disclosed for use within the MyChart system.

- This authorization is effective until my MyChart account is inactivated and includes records that were created or existing on or before the date this authorization was signed, as well as records that are created after the date this authorization is signed.
- I understand that the information to be released may include information relating to the diagnosis and/or treatment of mental illness, alcohol/drug abuse, STDs, HIV test results, developmental disabilities, and genetic testing results.
- I understand that I have a right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing and mail it to: Medical College of Wisconsin, Office of Clinical Informatics, 9200 West Wisconsin Avenue, Milwaukee, WI 53226. I understand that the revocation will not apply to information that has already been released.
- I understand that, if the persons or organizations I authorize to receive and/or use the ePHI described in this form are not health plans, covered health care providers or health care clearinghouses subject to the federal health information privacy laws, they may further disclose the ePHI and it may no longer be protected by federal health law.
- I may refuse to sign this authorization and understand that my refusal to sign will not affect my ability to obtain treatment. If I refuse to sign this authorization, access to my MyChart account will not be granted.

X_____/_____/_____/_____

Proxy Signature **Relationship to Patient** **Date** (Required) **Time** (Required)

X_____

Witness Signature

Medical Records Copy

Place Cadence Label Here