Child Proxy Form
0 - 11 Years Old

To sign up for access to your child's MyHealth@MorrisHospital, please complete both pages of this Child Proxy Form. Please note that your child's chart will be accessed through your MyHealth@MorrisHospital. Completing this form will establish a MyHealth@MorrisHospital account for you and for your child.

I agree to allow access to:

☐ **Billing** ☐ **Clinical Data** ☐ **Family History** ☐ **Download Medical History** ☐ **Profile**

If you would like to give full access please check all boxes above.

Parent/Guardian Information (all sections required – please print clearly.)

This section should be completed by the parent/guardian requesting access to a child's MyHealth@MorrisHospital

Name (last, first, middle initial) _____Date of Birth_____

Last 4 Digits of Social Security Number(optional) _____ Email: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Relationship to patient _____

Age Range Limitations

State and Federal law restricts parental access to certain medical information for children age 12-17. The information you are allowed to view will depend on the age of your child. You may be allowed to request additional information on paper or other electronic format by submitting a written request using a Release of Information Form that may be obtained from the Morris Hospital website. Records Request | Morris Hospital.

- If your child is age 0-11, you will be granted full access to your child's MyHealth@MorrisHospital record.
- Once your child reaches the age of 12, you will no longer have access to your child's MyHealth@MorrisHospital record.
- If your child is age 12-17 you may be granted access to your child's MyHealth@MorrisHospital record. Please use the Child Proxy Form 12-17 Years Old to be granted access to your child's MyHealth@MorrisHospital record.

Please return this form using one of the following methods:

Email: myhealthmedicalrecords@morrishospital.org

Mail: Morris Hospital & Healthcare Centers (Attn: Medical Records) 150 W. High St Morris, Il 60450

Fax: Morris Hospital Medical Record Department Secure Fax 815-942-3203

MORRIS HOSPITAL & HEALTHCARE CENTERS

Child Proxy Form
0 - 11 Years Old

Child Information

Please provide the following information for each child: All fields are required.

If you have more than six children for whom you would like proxy access, please print an additional form.

Child 1 Name (last, first, middle initial) _____

Date of Birth: _____/_____/_____ Gender ☐ Male ☐ Female

Street Address: _____ City: _____ State: _____ Zip: _____

Child 2 Name (last, first, middle initial) _____

Date of Birth: _____/_____/_____ Gender ☐ Male ☐ Female

Street Address: _____ City: _____ State: _____ Zip: _____

Child 3 Name (last, first, middle initial) _____

Date of Birth: _____/_____/_____ Gender ☐ Male ☐ Female

Street Address: _____ City: _____ State: _____ Zip: _____

Child 4 Name (last, first, middle initial) _____

Date of Birth: _____/_____/_____ Gender ☐ Male ☐ Female

Street Address: _____ City: _____ State: _____ Zip: _____

Child 5 Name (last, first, middle initial) _____

Date of Birth: _____/_____/_____ Gender ☐ Male ☐ Female

Street Address: _____ City: _____ State: _____ Zip: _____

MORRIS HOSPITAL & HEALTHCARE CENTERS

Child Proxy Form
0 - 11 Years Old

MyHealth@MorrisHospital Terms and Agreement

- I understand that MyHealth@MorrisHospital is intended as a secure online source of confidential medical information. If I share my MyHealth@MorrisHospital user ID and password with another person, that person may be able to view my or my child's health information and health information about someone who has authorized me as a MyHealth@MorrisHospital proxy.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.
- I understand that MyHealth@MorrisHospital contains select limited medical information from a patient's medical record and that MyHealth@MorrisHospital does not reflect the complete contents of the medical record. I also understand that a paper copy of a patient's medical record may be requested from the patient's clinic or Morris Hospital.
- I understand that my activities within MyHealth@MorrisHospital may be tracked by computer audit and that entries I make may become part of the patient's medical record.
- I understand that access to MyHealth@MorrisHospital is provided by Morris Hospital & Healthcare Centers as a convenience to its patients and that Morris Hospital & Healthcare Centers has the right to deactivate access to MyHealth@MorrisHospital at any time for any reason. I understand that use of MyHealth@MorrisHospital is voluntary and I am not required to use MyHealth@MorrisHospital or to authorize a MyHealth@MorrisHospital proxy.
- By signing below, I acknowledge that I have read and understand this MyHealth@MorrisHospital form and agree to its terms.

Access to children's online records is only available to parents or individuals with legal guardianship.

— I have read and understand the requirements and procedures for accessing my children's medical record information online as provided in this document.

— I certify that I am the parent or legal guardian of the child listed on this form and that all information I have provided is correct.

— I hereby request access to my child's online health record.

_____ _____/_____/_____

Signature of Parent/Guardian Date (required)

_____ _____

Printed Name of Parent/ Guardian Relationship to Patient

Office Use Only:

MR# or DD# _____ Release Completion Date: _____ By :_____(mnemonic)

 All 3 pages must be completed and returned