MORRIS HOSPITAL
& HEALTHCARE CENTERS

Minor Proxy Form
12-17 Years Old

Parent/Legal Guardian Access to the MyHealth@MorrisHospital of a Patient 12 to 17 Years Old

Requirements and Procedures:
Under State and Federal law there are certain types of medical information that the parent or guardian of a minor patient age 12-17 may not view without consent of the minor patient. Because of these requirements, a parent or legal guardian may access MyHealth@MorrisHospital medical record of a patient 12-17 years old only with the patient's consent. Both the minor aged 12-17 and the patient/legal guardian must sign this form.

Requirements for accessing a minor's record:
- Birth parent of individual requesting access must have legal guardianship rights
- Parental authorization form must be completed and signed
- Each parent or individual requesting access must have their own MyHealth@MorrisHospital account or a MyHealth@MorrisHospital account will be established

I understand that:
- I must have a MyHealth@MorrisHospital account or an account will be established for me
- I must log in to MyHealth@MorrisHospital with my own User ID & Password
- I must click on 'Change Person' to access the minor's medical information
- I agree to abide by the terms and agreement (below) of the MyHealth@MorrisHospital site
- MyHealth@MorrisHospital is not to be used in an emergency

Birth Parent/Legal Guardian access to a minor's record is revoked when:
- Birth parent/legal guardian or minor submits a request or revokes online
- Minor turns 18 years old
- Minor advises Morris Hospital & Healthcare Centers of his/her emancipated status
- Parent/Parent or Parent/Minor access disputes cannot be resolved

Morris Hospital & Healthcare Centers reserves the right to revoke online access to medical information at any time.

MyHealth@MorrisHospital Terms and Agreement:
- I understand that MyHealth@MorrisHospital is intended as a secure online source of confidential medical information. If I share MyHealth@MorrisHospital ID and password with another person, that person may be able to view my or the minor's health information, and health information about someone who has authorized me as a 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 selected, 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 the patient's medical record may be requested from the patient's clinic or the hospital.
- I understand that my activities within MyHealth@MorrisHospital may be tracked by computer audit and that entries I make may become part of 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 in certain circumstances. 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.
- This form does not substitute as an Authorization to Release health information to a designated proxy by any other method. The purpose of this Minor Proxy form is for access to the MyHealth@MorrisHospital information.

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Authorization Form

Please enter Patient's information below:

Name (last, first, middle initial): ________________________________ Gender ☐ Male ☐ Female ☐ Other

Last 4 Digits of patient's Social Security Number: _________Date of Birth: ________/_________/__________

Address/City/State/Zip: ____

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

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

Relationship to patient: ☐ Parent ☐ Legal Guardian

Access to patient's online record is only available to parents or individuals with legal guardianship.

I have read and understand the requirements and procedures for accessing the minor's medical record information online as provided on page one of this document titled *Minor Proxy Form 12-17 Year Old*. I certify that I am the parent or legal guardian of the minor listed above and that all information I have provided is correct. I hereby request access to the minor's online record.

Parent/Legal Guardian Printed Name______________________________ Date of Birth ____/____/___

Parent/Legal Guardian Signature ___________________________________ Date _____/______/______

Phone number: ___________________________ Email address:______________________________

I agree to allow access to:

For Patients (12-17 years of age)

- I agree to allow my parent/legal guardian, named above, online access to my medical information currently available and that may become available as a result of future medical care. I understand this authorization will expire upon my 18th birthday from the date of my signature and that I may revoke this access at any time.
- I understand that the following items may be disclosed along with other health information in my medical record: HIV/AIDS related health information and/or records, behavioral or mental health information and/or records, information about sexually transmitted disease (STD), pregnancy, birth control, drugs/alcohol diagnosis, treatment, and/or referral information, genetic testing information and/or records, information about sexual assault/abuse, information about minor abuse and neglect, and domestic abuse of an adult with disability.
- Patients/Minors Signature ____ Date _____/____/_____

Witness Signature ____ Date _____/____/_____

Witness relation to patient (witness can not be parent/legal guardian)__________________________________

Must be completed in its entirety or will be denied

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

Office Use Only:

MR# or DD# __________________ Release Completion Date: ________ By :_____________(mnemonic)