MyChart Family Access Form: For Patient 13 – 17 Years Old

With Family Access, you can designate someone to view your health record using MyChart. This individual, called your Proxy, may be a parent or legal guardian involved in your healthcare. Because you are age 13 or older, you have the right to privacy regarding your health information in MyChart and are not required to designate a MyChart Proxy.

Designating a parent or legal guardian as your MyChart Proxy does not give them new rights to give or withdraw consent for your procedures, services, admissions, discharges, organ donations, autopsies, or life support, different from the rights they may or may not have today.

To designate a parent or legal guardian as your MyChart Proxy, you must complete this form. By signing this form, your Proxy will receive email notifications about your MyChart and be able to:

- View your Allegheny Health Network electronic health information in MyChart from physicians, hospitals, and other healthcare providers who use the Epic record. This will include information related to diagnosis and/or treatment of HIV, mental health, drug and alcohol-related conditions, pregnancy, and/or sexually transmitted diseases.
- Communicate with your healthcare providers regarding tests, treatments, medications, medical advice, and administrative issues using MyChart secure messaging.
- Request and schedule appointments on your behalf using MyChart.
- Complete health questionnaires and request changes to your health record on your behalf using MyChart.

MyChart billing and payment information is only visible to the guarantor of your insurance plan, using their MyChart account. Your Proxy will not be able to view or act on your billing or payment information using MyChart unless they are your guarantor.

By signing this form, my Proxy and I acknowledge the following:

- We have read and understand this MyChart Family Access Form and its terms and conditions and choose to make the parent or legal guardian named on this form a MyChart Proxy of the patient's health record.
- The patient's treatment will not be affected in any way, whether we sign or do not sign this form. Signing this form is not required to receive treatment.
- The parent or legal guardian on this form will remain a MyChart Proxy to the patient's health information until one of the following occurs:
    - The patient terminates the Proxy relationship on the My Family Access Page of MyChart, during a visit with their doctor, or by calling the Department of Data Integrity at 412-330-5399.
    - The Proxy terminates their relationship with the patient the Department of Data Integrity at 412-330-5399.
    - The patient dies, and the Proxy relationship is automatically terminated.
    - The patient turns 18 years old, and the Proxy relationship is automatically terminated.
- The patient may terminate the Proxy relationship at any time for any reason. Any of the patient's electronic health information that is viewed or printed using MyChart before the patient terminates the Proxy relationship cannot be taken back.
- The parent or legal guardian may still have the right to request copies of the patient's legal medical records or services for which the parent or legal guardian has consented, even after the MyChart Proxy relationship is terminated.
- Allegheny Health Network reserves the right to revoke the Proxy's ability to view the patient's health record using MyChart at any time, for any reason.
- If the Proxy rediscloses the patient's protected health information, Allegheny Health Network is not liable for such redisclosure.

Patient
Complete the information below.

Name: _____ Date of Birth: _____

Home Address: _____

City, State, Zip Code: _____

Email Address: _____ Phone: _____

Signature: _____ Date: _____

Patient Representative
If signing on behalf of the patient, complete the information below and attach the appropriate documentation specifying your relationship to the patient and your authority to act.

Name: _____

Signature: _____ Date: _____

Parent or Legal Guardian
Complete the information below.

Name: _____ Date of Birth: _____

Home Address: _____

City, State, Zip Code: _____

Email Address: _____ Phone: _____

Signature: _____ Date: _____

Once completed and signed, please return this form to your doctor's office or mail it to the address below:
Health Information/Medical Records
Attn: Data Integrity
1301 Carlisle Street
Natrona Heights, PA 15056