

Proxy Request and Authorization Form for Access to MyChart™ Minor Patient Portal

Parents and legal guardians of minor patients can complete this form to request "proxy access" to the child's health information in University Health's MyChart™ Patient Portal. Proxy access enables you to view your child's health information in the Portal and communicate through the Portal with your child's health care team. In some cases, certain health information may be restricted from the MyChart account if the health care provider considers it to be in the best interest of the child. You must complete a separate form for each child for whom you are requesting proxy access.

All Sections Required-PLEASE PRINT

Section I. Patient (Child's) Info	ormation:			
Name:			DOB: /	1
Last	First	MI	,,,,,,	DD YYYY
Home Address:				
nome Address:	Street Address	City	State	Zip Code
Section II. Requestor (Parent/Legal Guardian) Information:				
Namai			DOP: /	
Name: Last	First	MI	DOB:/_ 	DD YYYY
Home Address:	Street Address	City	State	Zip Code
Phone #:	□Cell □Home □	•		·
Requestor's Email Address:				
Relationship to Patient: Parent Legal Guardian				
By signing this Proxy Request and Authorization Form, I acknowledge and agree that:				
I am the parent or legal guardian.				
I am not a CPS worker or a foster parent. Caretakers with temporary guardianship are not elgible for proxy accounts and must submit their				
requests for information through the Medical Records Department. There are no court orders or restraining orders in effect limiting the access to my child's medical records and/or information.				
 There are no court orders or restraining orders in effect limiting the access to my child's medical records and/or information. I am giving my permission for University Health to disclose my child's protected health information (PHI) through the MyChart™ Patient 				
Portal, which may include, but is not limited to: health summary, current problem list, current medications, lab results, appointment				
information. This may include information relating to 1) Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus				
 (HIV) infection, 2) treatment for drug or alcohol abuse or 3) mental or behavioral health or psychiatric care I will establish my own MyChart™ account in order to access my child's MyChart™ account. 				
After my child turns 13, certain health information may be withheld from the account.				
 Once my child turns 18, he/she has the authority under Texas Law to create their own access to MyChart™. 				
x				
	Guardian Signature	Relationship to F	Patient	Date
If you have any questions or need help completing this form, please contact the office below:				
Medical Records Department				
701 S. Zarzamora				
SanAntonio, TX 78207 Phone: (210)358-1777 FAX:(210)702-4088				
Office Use Only:				
Patient (Child's) MRNApproved; Manual Invite Sent On:Security Code:				
□Rejected: Reason:				

