TEEN PROXY FORM

Please complete the following information for access to a teen's (12-17) MyChart account at Duly Health and Care (Duly). Proxy access for minors under 17 years of age will only be granted to parents or legal guardians; each parent/legal guardian must complete a separate form. **Please note**: the patient's information will be accessed through the designated proxy's personal MyChart account and access is automatically terminated on the patient's 18th birthday.

Please email completed forms to mydmghealth@duly.com.

Parent/Legal Guardian Information (one form per parent/legal guardian)

Name (last, first, middle initial): _____

Date of Birth: _____ Phone Number: _____

Email Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Teen Patient Information

Name (last, first, M.I.): _____ Date of Birth: _____

MyChart Terms and Agreement

- Access to MyChart and proxy designation is provided by Duly as a convenience and is completely voluntary; Duly does not condition health care treatment or payment on its use.
- If I share my username and password with another person, that person may be able to view my health information, as well as information of those to which I have proxy access.
- 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.
- MyChart contains limited information and does not reflect the complete contents of the patient's medical record.
- Activities within MyChart may be tracked and may become part of the medical record.
- Duly has the right to deactivate my access to MyChart at any time for any reason.
- Duly and its medical groups: DuPage Medical Group and The South Bend Clinic, jointly provide MyChart to improve my coordination of and access to care.
- Information obtained through MyChart and re-disclosed by a designated proxy may not be covered by HIPAA.
- I may revoke this authorization at any time by providing a written request, which will end my access to my child's account. Revocations will not affect disclosures made prior to processing the request.
- This form does not authorize release of medical information to a designated proxy by other methods or other forms.

By signing below, I acknowledge that I have read and understand the above statements.

_____/_____/_____

Signature of Parent or Legal Guardian | Relationship to Patient | Date

I understand and authorize sensitive health information (SHI) related to the following may be disclosed to my parent/legal guardian: sexually transmitted diseases (STDs), mental health, pregnancy, birth control, substance abuse, genetic testing, and physical/sexual abuse. I understand I may revoke this authorization at any time by providing a written request, which will end my proxy's access to my account. Revocations will not affect disclosures made prior to processing the request.

_____/_____

Signature of Patient/Teen | Date

_____/_____/_____

Signature of Witness, other than parent or legal guardian | Relationship to Patient | Date