The Portland Clinic

Child's Name_____
Date of Birth _____
Medical Record Number _____

Request for Access to the MyChart of a Minor Patient

If you are the parent or legal guardian of a child from birth through age 17, you may use this form to request access to the child's online Portland Clinic electronic medical record and other online services.

This section should be completed by the individual requesting access to the child's chart.

Parent's/Legal Guardian's Name (last, first, middle initial)		Social Security Number
Date of Birth	E-mail Address	Telephone #
Address	City	State/Zip

- **If you are not the birth or adoptive parent (example: stepparent, grandparent), you must provide documentation that establishes that you are a legal guardian for the above-named child.**
- **Patients ages 13-17 must complete the Authorization to Release Medical Information – MyChart Only form (found on page 2). *This form must be completed by the patient.* This form is not needed for patients under the age of 13.**
- Some information within MyChart regarding minors between the ages of 13-17 years old may be limited according to Oregon and federal privacy laws.
- Access to a child's Portland Clinic record is available only to parents or legal guardian's with full legal authority to make health care decisions for the above-named child.
- The child's MyChart account will be accessed through the proxy's MyChart account. If the proxy does not have a MyChart account with The Portland Clinic, they will be provided with information to create their own account even though the proxy holder may not be a patient at The Portland Clinic.

Declaration and Acknowledgment

I have read and understand the requirements and procedures for accessing my child's Portland Clinic medical record.
I certify that I am the parent or legal guardian of this child. I hereby request access to my child's medical record at The Portland Clinic.
Should my legal authority to make health care decisions for this child change in the future, I will inform the The Portland Clinic immediately.

My legal access to my child's medical record will be revoked when: I submit a request to revoke; the child turns 18; or the child informs The Portland Clinic of emancipated status.

I agree to abide by the same terms and conditions set forth in the Terms of Use Agreement that I accepted when I was granted access to a MyChart account. I understand that The Portland Clinic reserves the right to revoke MyChart access at any time for any reason. In addition, I am aware that all secure messages between me and my child's health care team will become part of my child's medical record and that my online access to the child's personal health information will be limited by law when he/she reaches age 13 and revoked at 18.

I declare under penalty of perjury under the laws of the State of Oregon that the above is true and correct.

Parent/Legal Guardian (Signature) (Same as above)	**Date**

Authorization to Release Medical Information – MyChart Only

Only minor patients ages 13-17 need to complete this form

Patient Name: _____ DOB: _____ Former Name: _____

Current Address: _____ City: _____ State: ____ Zip: _____

Daytime Phone: _____ Evening Phone: _____ SS#: _____

I Authorize the Release of Medical Information

FROM The Portland Clinic, To the Following Parent or Legal Guardian:

Name: _____

Address: _____

City: _____ State: ___ Zip: _____

Purpose of Release: Access to MyChart Record

I understand that certain information cannot be released without specific authorization as required by state/federal law. I authorize the disclosure of all information maintained in my MyChart record. By initialing below I authorize the release of the following protected or sensitive information as it may pertain to me (all of the following items ***must be initialed*** to authorize access to your MyChart record):

____ AIDS/HIV test results including related high-risk behavior

____ Other sexually transmitted diseases

____ Mental health/treatment

____ Drug abuse diagnosis/treatment

____ Alcoholism diagnosis/treatment

Federal and/or state law may restrict redisclosure of HIV-positive test results and HIV diagnosis, other sexually transmitted disease information, mental health information, genetic information, and drug/alcohol diagnosis, treatment or referral information.

By signing this form, you are authorizing the use or disclosure of your protected health information as described above. This information may be redisclosed if the recipient is not required by law to protect the privacy of the information.

You have the right to revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received prior to release of information. Unless otherwise revoked, this authorization will remain in effect for so long as I maintain a MyChart account. Although, if I am under the age of 18, this authorization will expire when I turn 18 years old.

The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing my health information to someone else, and this authorization is needed to make that disclosure. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization, with the exception of obtaining information in connection with eligibility or enrollment in a health plan.

If anyone other than the patient is completing this form proof of legal authority is required.

_____ _____ _____

Signature of Patient or Person with Legal Authority | Relationship to Patient | Date

_____

Print Name