Child Proxy Form

Access to Your Child's MyChart Record

To sign up for access to your child's MyChart record, please complete both pages of this Child Proxy Form and return it to the address shown below. Please note that your child's chart will be accessed through your MyChart record. Completing this form will establish a MyChart record for you and for your child.

Please return the forms to:

Health Information Management Services
Texas Health Resources
500 E. Border St – Suite 700
Arlington, TX 76010
HIMSROI@texashealth.org
or Fax to: 682-236-7126

Mother or Guardian Information: (All fields **required** except as noted – please print clearly.)

Name (*last, first, middle initial*) _____

Date of Birth: _____ Email Address: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____

Primary Clinic (Optional): _____

Father or Guardian Information: (All fields **required** except as noted – please print clearly.)

Name (*last, first, middle initial*) _____

Date of Birth: _____ Email Address: _____

☐ **Check box when address is the same as above**

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____

Primary Clinic (Optional): _____

Please note the following age range limitations for MyChart. These age range limitations do not affect any legal right you have to access your child's record by other means. To request a paper copy of your child's record, contact your child's primary care clinic.

- If your child is **age 0-15:** You will be granted full access to your child's MyChart record.
- If you child is age **15-17**: You will be granted restricted access to your child's MyChart record.
- Once your child reaches **age 18,** you will no longer have access to your child's MyChart record.

Please provide the following information for each child: (All fields are **required**. If you have more than four children for whom you would like proxy access, please request another form). *****Please note that children have to be a previous patient at a Texas Health Resources hospital or clinic in order for proxy access to be setup.***

A. Name *(last, first, middle initial)*: _____

Date of Birth: _____

Primary Clinic (Optional): _____

B. Name *(last, first, middle initial)*: _____

Date of Birth: _____

Primary Clinic (Optional): _____

C. Name *(last, first, middle initial)*: _____

Date of Birth: _____

Primary Clinic (Optional): _____

D. Name *(last, first, middle initial)*: _____

Date of Birth: _____

Primary Clinic (Optional): _____

MyChart Terms and Agreement

- I understand that MyChart is intended as a secure online source of confidential medical information. My MyChart ID and password cannot be shared with anyone because that person will be able to view my or my child's health information. This action can result in revocation of MyChart access to my records and my child's records.
- 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 MyChart contains selected, limited medical information from a patient's medical record and that MyChart does not reflect the complete contents of the medical record. I also understand that a paper copy of a patient's medical record may be requested from the patient's clinic.
- I understand that my activities within MyChart may be tracked by computer audit and that entries I make may become part of the medical record.
- I understand that access to MyChart is provided by Texas Health Resources as a convenience to its patients and that Texas Health Resources has the right to deactivate access to MyChart at any time for any reason. I understand that use of MyChart is voluntary and I am not required to use MyChart or to authorize a MyChart proxy.
- By signing below, I acknowledge that I have read and understand this MyChart Sign-Up Form and I agree to its terms.

Please Circle One

▶ _____ / **Mother Guardian** / _____

Signature of Mother or Guardian *(Required)* | **Relationship to Patient *(Required)*** | **Date *(Required)***

Please Circle One

▶ _____ / **Father Guardian** / _____

Signature of Father or Guardian *(Required)* | **Relationship to Patient *(Required)*** | **Date *(Required)***