MyHealth Info Parent/Guardian Form

Access to Your Child's MyHealth Info Record

To sign up for access to your child's MyHealth Info record, please complete both pages of this parent/guardian form and return it to the address shown below. Please note that your child's chart will be accessed through your MyHealth Info record under account profiles. Completing this form will establish a MyHealth Info record for you and for your child.

Return all forms to: MyHealth Info Information
Health Information Services
2000 North Avenue
Northfield, MN 55057

Parent/guardian Information: (all sections required- please print clearly)

Name: (last, first, middle initial) _____

Last 4 digits SSN: _____Date of Birth: _____

Street Address: _____City: _____State: _____ Zip: _____

E-mail Address: _____ Phone number: _____

Please note the following age range limitations for MyHealth Info. 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.

- **Age 0-12:** you will be granted full access to your child's MyHealth Info record.
- **Age 13 and above**: you or your child will no longer have access to your child's MyHealth Info 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.

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

Last 4 digits SSN: _____ Date of Birth: _____

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

Last 4 digits SSN: _____ Date of Birth: _____

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

Last 4 digits SSN: _____ Date of Birth: _____

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

Last 4 digits SSN: _____ Date of Birth: _____

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MyHealth Info terms and agreement

- **I understand that MyHealth Info is intended as a secure online source of confidential medical information. If I share my MyHealth Info ID and password with another person, that person may be able to view my or my child's health information, and health information about someone who has authorized me as a MyHealth Info user on their account.**
- **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 confidentiality may have been compromised in any way.**
- **I understand that MyHealth Info contains selected, limited medical information from a patient's medical record and that MyHealth Info 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 MyHealth Info may be tracked electronically and that entries I make may become part of the medical record.**
- **I understand that access to MyHealth Info is provided as a convenience to patients and that MyHealth Info Services has the right to end access to MyHealth Info at any time, for any reason.**
- **I understand that my use of MyHealth Info is voluntary and I am not required to use MyHealth Info or to authorize any other as a MyHealth Info user on my account.**
- **I understand if I choose to use the share feature on MyHealth Info, that it is my responsibility to maintain the type of access shared and to revoke the access as necessary.**

➢ _____

Signature of patient/authorized person **Relationship to patient** **Date (required)**