MyHealth Info Legal Custodian Form

Access to an Adult's MyHealth Info Record

To request access to MyHealth Info of an adult whose medical care you help manage and are legal custodian, please complete this form. You must provide legal documentation of custodial/guardianship. Please note that the patient's chart will be accessed through your (not the patient's) MyHealth Info record. Completing this form will establish a MyHealth Info record for you and for the patient.

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

Your Information (all sections required-please print clearly)

This section should be completed by the individual requesting access to another adult's *MyHealth Info* record.

Name: (last, first, middle initial) _____

Last 4 digits SSN: _____ Date of Birth: _____

Street address: _____City: _____ State: _____ Zip: _____

E-Mail address: _____Phone Number: _____

Patient's 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: _____

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 MyHealth Info 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)**