

## Access to Your Child's or a Minor's MyUHealthChart Record

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

Please return all forms to: University of Miami workforce member.

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### Parent/Guardian Information: *(All sections required – please print clearly.)*

Name *(last, first, middle initial)* \_\_\_\_\_

Last four digits of Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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

- If the child is **age 0-11**: You will be granted full access to the minor's MyUHealthChart record, but the information in MyUHealthChart may not be the complete medical record. Please see the MyUHealthChart terms and conditions.
- Once the child reaches **age 12**, you will no longer have access to the minor's MyUHealthChart record, unless he/she grants you proxy access through the Adult Proxy Access form.

**Please provide the following information for each minor:** (All fields are required. If you have more than four children for whom you would like proxy access, please request another form or print one from [www.MyUHealthChart.com](http://www.MyUHealthChart.com) FAQ page. **(Required)**)

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

Last four digits of Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Last four digits of Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Last four digits of Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Last four digits of Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Please remember to complete page 2 of this form.

Please check y

- Parent  Legal Guardian\*\*  Non-Custodial Parent\*\*  Durable Power of Attorney for Healthcare\*\*  
 Other (specify)\_\_\_\_\_

*\*\*If you are the legal guardian or the non-custodial parent of the minor or if you have a durable power of attorney for healthcare with regard to the minor, then this request **MUST** be accompanied by a copy of legal paperwork verifying your authority to have access to the minor's medical information (for example: a court order appointing you the guardian, durable power of attorney for health care, birth certificate, child custody order, etc).*

Is there a court order in effect limiting the parent/legal guardian's access to this child's medical records and information? Yes \_\_\_\_\_

No \_\_\_\_\_. If yes, please provide legal documents. **(Required)**

## MyUHealthChart Terms and Agreement

- I understand that MyUHealthChart is intended as a secure online source of confidential medical information. If I share my MyUHealthChart 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 MyUHealthChart proxy.
- 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 MyUHealthChart contains selected, limited medical information from a patient's medical record and that MyUHealthChart 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 MyUHealthChart may be tracked by computer audit and that entries I make may become part of the medical record.
- I understand that access to MyUHealthChart is provided by University of Miami as a convenience to its patients and that University of Miami has the right to deactivate access to MyUHealthChart at any time for any reason. I understand that use of MyUHealthChart is voluntary and I am not required to use MyUHealthChart or to authorize a MyUHealthChart proxy.
- I agree to abide by the terms and conditions of the MyUHealthChart site.
- I understand that when my child/minor turns 12 years old, access will be automatically terminated.
- **MyUHealthChart is not to be used in an emergency.**
- University of Miami reserves the right to revoke online access to MyUHealthChart at any time and in its sole discretion.
- Communications on behalf of the minor must be sent from the minor's record and responses will be received in the minor's record. MyUHealthChart email alerts will be sent to the email address entered in the minor's record.
- I understand, that under Florida law, University of Miami cannot provide a proxy access to certain types of medical information without the specific consent of the minor patient. As a proxy, I agree to these limitations on access to information in MyUHealthChart.
- By signing below, I acknowledge that I have read and understand this MyUHealthChart Proxy Form and I agree to its terms.

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Signature of Parent/Guardian (Required)

Relationship to Patient (Required)

Date (Required)