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**Parental/Guardian Proxy Access to a Child's MyChart Record**

Caring Health Center, Inc. provides access to a child's electronic health information in MyChart to parents or legal guardians for children at or under the age of 11 years old. To sign up to access your child's MyChart record, please complete this parental/legal guardian proxy authorization form and return it to Caring Health Center. This form is an authorization that will permit Caring Health Center to release your child's medical information to you via MyChart. This form should be completed by the parent or legal guardian who is authorizing Caring Health Center to allow parental access to their child's MyChart electronic record. This form must include the parent or legal guardian's name and information, and the child's name and information.

**Child/Patient Name** *(last, first, middle initial)* \_\_\_\_\_  
*(last, first, middle initial)*

**Child/Patient Mailing Address:** \_\_\_\_\_

**Child/Patient Date of Birth:** \_\_\_\_\_  
MM/DD/Year

I am requesting that I, \_\_\_\_\_  
*(insert printed name of parent or legal guardian)*

receive proxy access to my child's electronic health information that is available in my child's MyChart electronic record. I understand that MyChart contains a portion of my child's medical record and that MyChart does not reflect the complete contents of the medical record. I authorize Caring Health Center, Inc. to release the health information contained in my child's MyChart record to me. I understand that the medical information in MyChart is obtained from my child's electronic medical record and that it may include information from facilities listed in Caring Health Center's Notice of Privacy Practices. **Information in MyChart may include pregnancy, STD treatment, reproductive health care, alcohol and/or substance abuse treatment, genetic testing, mental health or HIV related information, such information may only be included in your child's MyChart record if permitted by state law.**

This form does not authorize release of my child's medical record to anyone else by other methods or in other ways. Participation in MyChart and designating a parent/guardian MyChart proxy is completely voluntary. Access to my child's MyChart electronic record is solely at my request. I understand that I am not required to designate a parental MyChart proxy for my child's record, and I am not required to request MyChart access authorization for any other person. I also understand that Caring Health Center does not condition any of my child's health care treatment, payment or other services on whether or not I provide this parent proxy authorization. However, I also understand that if I do not provide this MyChart authorization, Caring Health Center, Inc. will not provide me with access to my child's MyChart record. I understand that once I receive access to my child's MyChart records any redisclosure by me of the information contained in such records may not be protected by federal privacy protections.

This authorization will expire when my child reaches 12 years of age or when I request that Caring Health Center remove my access. I understand that Caring Health Center may remove my access to my child's electronic record at any time and will do so as required pursuant to state law. I understand that I may revoke this authorization at any time prior to my child's 12th birthday, by providing a written request for revocation to Caring Health Center. I understand that if I revoke this authorization, my access to my child's MyChart record will be ended. I also understand my revocation will not affect any disclosures that were made prior to processing the revocation request. I certify that I am the parent or legal guardian of the child listed above and that all information provided is correct. I hereby request access to my child's MyChart electronic record. I have been provided a copy of this authorization.

**Signature of Parent or Legal Guardian:** \_\_\_\_\_

**Relationship to the Patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_  
MM/DD/Year

**Printed Name of Parent or Authorized Representative:** \_\_\_\_\_

**Parent or Legal Guardian's Mailing Address:** \_\_\_\_\_

If a person other than the parent or legal guardian signs this form, indicate their legal authority to sign for patient, and attach any documentation: