

Return form to: 793 Sawyer Rd. Suite 1335
Marietta, GA 30062

OR Fax form to: 770-999-2306

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 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 your child.

Parent / Guardian Information (all sections are required unless otherwise noted - please print clearly):

Parent Name (Last, First, Middle Initial): _____
Social Security Number (optional): _____ Date of Birth: _____
Street Address: _____
City: _____ State: _____ Zip: _____ Phone Number: _____
Email Address: _____
Primary Physician: _____

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 provider.

- If your child is **age 0 to 11**: You will be granted full access to your child's MyChart record.
- If your child is **age 12 to 17**: You will be granted partial access to your child's MyChart record (e.g. appointment scheduling, immunizations).
- When 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 unless otherwise noted. If you have more than 4 children for whom you would like proxy access, please request another form from your child's physician, or make a copy of this form.

1. Child Name (Last, First, Middle Initial): _____
SSN (optional): _____ Date of Birth: _____
Primary physician: _____
2. Child Name (Last, First, Middle Initial): _____
SSN (optional): _____ Date of Birth: _____
Primary physician: _____
3. Child Name (Last, First, Middle Initial): _____
SSN (optional): _____ Date of Birth: _____
Primary physician: _____
4. Child Name (Last, First, Middle Initial): _____
SSN (optional): _____ Date of Birth: _____
Primary physician: _____

PLEASE BE SURE TO SIGN PAGE 2 OF THIS FORM





MyChart Terms and Conditions

I understand that MyChart is intended as a secure online source of confidential medical information. If I share my MyChart ID and password with another person, that person may be able to view my or my child's health information and information about someone who has authorized me as a MyChart 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 MyChart contains selected, limited medical information from a patient's medical records 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 WellStar's Release of Information Department at 770-810-8880.

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 WellStar Health System as a convenience to its patients and that WellStar Health System 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.

I acknowledge that I have read and agree to these terms and conditions.

_____/ _____ / _____
Signature of Parent/ Authorized Person Relationship to Patient Date

_____/ _____ / _____
Signature of Parent/ Authorized Person Relationship to Patient Date