

MyChart® Informed Consent for Adolescent Patients Form

Patient Information: (please print clearly)

Patient Name (first, middle, last) _____

Social Security Number: _____ Date of Birth: _____

Street Address: _____ City: _____

Phone Number: _____ State: _____ Zip: _____

MyChart Personal Health Record\Electronic Communication

I am requesting access to the MyChart® Record(s). In accessing or otherwise communicating through MyChart®, I agree to abide by the guidelines for the MyChart Patient Portal electronic communication, as outlined below. I understand that MyChart® is not intended for critical or time sensitive communication. I understand that if the individual(s) for whom I have proxy access requires immediate or urgent care, I am to contact 911 or the individual's health care provider ("Provider") directly (NOT through MyChart®). My failure to adhere to the following guidelines may result in limitation of functionality in MyChart. I agree never to use MyChart® to communicate information related to substance use disorder, if any.

When using MyChart I agree to:

- Contact the health care professional by means other than MyChart for any urgent or emergent situations.
- Avoid communication related to chemical dependence, such as alcohol and substance abuse due to Privacy laws.
- Be concise in my communication.
- Avoid using MyChart messaging as a replacement for a phone call consultation or medical appointment.
- Results are immediately released. Reviewing laboratory or imaging results without consultation from your provider may lead to unnecessary concern or inappropriate interpretation.

I understand that my Provider or a designated staff member will:

- Require that I contact the health care professional by means other than MyChart for any urgent or emergent situations.
- Maintain certain activities with MyChart as part of my Provider's medical record.
- Use reasonable and appropriate security practices to protect electronic patient information and prevent unauthorized access (password protection, encryption, proxy authorizations, etc.)
- Share MyChart communications with office staff and other healthcare providers as needed, for continuity of care and where allowed without patient authorization.
- Share all medical and billing information with the Patients MyChart Proxy, including laboratory and images results, family history, clinician notes, mental health treatment records.

I understand that MyChart will notify me via email or SMS text that new messages are available in MyChart. Such messages will not contain any additional health information. I hereby request access to MyChart and understand that in order to gain access to MyChart I will be given a confidential password. I agree to keep it confidential and not share it with anyone else. I understand that my use of MyChart is subject to certain terms and conditions. I agree to review MyChart terms and conditions attached hereto before accessing MyChart and further agree that by accessing MyChart I am agreeing to abide by the MyChart terms and conditions, as those terms and conditions are amended from time to time and accessible at <https://www.franciscanmychart.org>. I understand that any updated terms and conditions in effect will be reviewable to me at the time I sign in to MyChart and I must accept the new terms and conditions before proceeding.

I have read all of the above, asked questions, and received answers concerning areas I did not understand.

Signature of Patient: ► _____ Date: _____

I hereby consent to allow access to MyChart for the unemancipated minor noted above and I agree to the terms noted above. I understand that the adolescent access will include but not limited to medical and billing information, laboratory and images results, family history, gene-related impairments (including genetic test results), clinician notes, substance abuse and mental health treatment records. I understand my consent will no longer be required if the minor becomes emancipated or reaches the age of majority.

► _____
Signature of Parent/Guardian Relationship to Patient Date