Patient Label

MyCare Parent/Guardian Access Authorization

To request access to the MyCare record of your minor child or patient for whom you have legal guardianship, please complete this form and return it to the Trinity Health Of New England MyCare Support Team by scanning it and emailing it to: mycaresupport@trinityhealthofne.org

MINOR PATIENT INFORMATION (please complete all requested info)	
Patient Name:	**DOB:**
Street Address:	**Email** (if applicable):
City, State, Zip:	**Phone:**
Last 4 digits of SSN:	

PARENT/GUARDIAN INFORMATION (please complete all requested info)	
Proxy Name:	**DOB:**
Street Address:	**Email** (required):
City, State, Zip:	**Phone:**
Last 4 digits of SSN:	**Relationship to Patient:**

Proxy Agreement to MyCare Terms and Conditions

As a parent/guardian of the patient named above, I understand and agree to the following:

- MyCare contains selected, limited medical information from the patient's medical record and does not reflect the complete contents of the medical record. A paper copy of the patient's medical record may be requested from the patient's health care provider.
- If the child is between 0 and 11 years old, then I will have full access to the child's MyCare account.
- If the child is between 12 and 17 years old, then I will have limited access to the child's MyCare account.
- If the child is over 18 years old, then I will not have access to the child's MyCare account, unless the patient and I complete and submit the Trinity Health Of New England Proxy Access Authorization Form.
- My activities within MyCare are tracked by computer audit, and entries I make can become part of the above-named patient's medical record.
- I understand that my access to any information about the patient may be revoked/terminated by Trinity Health Of New England at any time without notice.
- I agree to abide by the Trinity Health Of New England MyCare Terms and Conditions, which are available at: https://mycare.stfranciscare.org/mycare/default.asp?mode=stdfile&option=termsandconditions.

By signing below, I acknowledge that I am authorized to access the protected health information of the patient described above. I certify that I am legally authorized to access such information about the patient named above, and that the information I have provided is true and correct.

Parent/Guardian: Date: Time: