South Shore Health

MyChart - Adolescent Access

Adolescent access for MyChart allows an adolescent patient between the ages of 13 to 18 to view components of their medical record and communicate with their physician's office regarding non-urgent matters. The parent or legal guardian will also be able to view a limited portion of the adolescent's medical record and communicate with the physician's office.

Adolescent proxy access is terminated when the parent/legal guardian makes a written or online request to terminate access. At age 18 the patient will have full control of their MyChart account and the parent/legal guardian access will be discontinued. Beyond the age of 18 the patient may still grant parent/legal guardian access by requesting Adult Proxy access.

Adolescent Access and Adolescent Proxy Terms and Conditions:

- The parent/legal guardian must complete and sign the attached Adolescent Proxy Authorization Form. Please call MyChart Support at 781-261-4480 if you need assistance.
- **Important**: You can print and fill-out this form at home but it will only be accepted if delivered to our office in person by the adolescent.
- Each parent/legal guardian requesting access must have an active MyChart account but, he/she does not need to be a South Shore Health System patient.
- Adolescent access can be terminated by the parent/legal guardian at any time online or by written request.

  For existing Pediatric Proxy MyChart accounts, the parent/legal guardian's access to MyChart will continue when the child turns 13, but the access will be limited as noted below.

MyChart access will enable you to:

Adolescents:	Parents / Legal Guardians:
• View growth charts, immunizations, allergies and medications	• View growth charts, immunizations and allergies
• Communicate with your physician's office on non-urgent issues	• Communicate with the physician's office on non-urgent issues
• View lab results	• View lab results
• Request, schedule, cancel appointments	• Schedule appointments (but you cannot cancel or review past/future appointments)
• View appointment history	• Request appointments
• View School/Camp forms and letters	
• Additional features may be enabled over time	• Additional features may be enabled over time

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Adolescent Proxy Authorization Form

Adolescent Proxy Access to MyChart for teens 13-18 years of age.

PATIENT'S INFORMATION

All fields are required – please print clearly

Patient's Name: _____ DOB: _____ Gender: ❑ Male ❑ Female

Address: _____ City, State, Zip: _____

Telephone No: _____ Email Address: _____

Primary Care Provider: _____

PROXY INFORMTION

(PARENT / LEGAL GUARDIAN)

All fields are required – please print clearly

Parent / Legal Guardian Name: _____ DOB: _____ Gender: ❑ Male ❑ Female

****** Only enter address if different from patient ******

Address: _____ City, State, Zip: _____

Telephone No: _____ Email Address: _____

Last 4 digits of SSN: _____ (Required for authentication purposes and will be stored securely in compliance with applicable laws.)

Are you a South Shore Health System (SSHS) patient? ❑ Yes ❑ No (Selecting "yes" indicates that the proxy requestor has a PCP or specialist at SSHS.)

If yes, please provide your clinician's name: _____

Confirmation and Authorization Signatures

I understand: MyChart will display limited medical information to the parent/legal guardian listed above. I have read and understand the guidelines regarding MyChart including secure patient messaging and agree to allow the parent/ legal guardian requestor noted above, to have access to my MyChart information. I also agree to abide by the terms and conditions for use of MyChart.

_____ _____

Date **Patient Signature**

I authorize the adolescent patient above to create a MyChart account. I have read and understand the requirements for accessing the above-named patient's MyChart account and agree to abide by these requirements.

This access will expire on the patient's 18th birthday. A photocopy of this authorization is as valid as the original. I certify that all the information I have provided is correct. I hereby request limited access to the above-named patient's MyChart.

_____ _____

Date **Parent/Legal Guardian Signature**

Internal Use Only:

Both adolescent and parent presented in person with this completed application: _____

Date

Initials of SSHS staff receiving form _____