Signature HEALTH

PARENT OR COURT-APPOINTED GUARDIAN REQUEST FOR MYCHART CAREGIVER ACCESS AUTHORIZATION FORM
MINOR PATIENT OR ADULT PATIENT WITH GUARDIAN

MyChart Cargiver is the individual who is authorized by the patient or law such as a patient's parent or court appointed guardian. The MyChart Caregiver will have access to portions of the patient's medical record through the MyChart Caregiver service. In order to provide the MyChart Caregiver with access to a patient's information, an account must be created for the MyChart Caregiver.

Please check the requestor's relationship to the minor patient:
- □ Parent
- □ Court-appointed guardian of the person**

Is there a court order or a restraining order in effect limiting the requestor's access to this patient's medical records and/or Information?
Please indicate: Yes/ No_____ If yes, please provide legal documents.

*** This request **MUST** be accompanied by a copy of legal paperwork verifying the requestor's authority as the patient's court-appointed guardian of the person.*

MyChart Caregiver Information:

MyChart Caregiver's Name: _____

MyChart Caregiver's Date of Birth:_____/_____/_____

MyChart Caregiver's Telephone #:_____

MyChart Caregiver's Current Street Address:_____

MyChart Caregiver's Email:_____

_____

SSN or Mychart Account number: _____

_____
MyChart Caregiver Signature

_____
Date

Patient Information:

Patient's Name:_____

Patient's Date of Birth:_____/_____/ _____

Patient's Medical Record #:_____

Patient's Current Street Address:_____

Patient's Telephone #:_____

_____

As the patient's parent or court-appointed guardian of the person, I hereby authorize Signature Health to release to me via MyChart Caregiver Access any and all health information contained in the MyChart account of the above-named patient for any purpose that I deem to be appropriate, according to the MyChart Caregiver Terms and Conditions, which will allow me to view, download, and/or transmit to third parties any and all of the patient's health information contained in MyChart. I understand and acknowledge that this may include information relating to the patient's treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnoses.

Once the patient's health care information is released, the information may be re-disclosed by the recipient and may no longer be protected by law. The patient's treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether you agree to this authorization. In order for this authorization to be valid, activation of the MyChart Caregiver access feature must occur within one (1) year of the date of this authorization. Upon receipt of this completed form, please allow approximately seven (7) business days for processing your MyChart Caregiver request.

I understand and agree that I must contact the Medical Records Department by telephone at (440)578-8200 or through written notice sent to Medical Records, 7232 Justin Way, Mentor, OH 44060 if I am no longer the above-named patient's court- appointed guardian of the person or if there is a court order or restraining order in effect that would limit my access to the patient's medical records and/or information. This authorization for my access to the patient's MyChart account will automatically expire when the patient reaches the age of majority, if the Medical Records Department receives notice and documentation that I am no longer the patient's court-appointed guardian of the person (if applicable), if the Medical Records Department receives notice and documentation that there is a court order or restraining order in effect that would limit my access to the patient's medical records and/or information, or when I revoke this authorization, whichever occurs first. You may revoke this authorization at any time, except to the extent that action has been taken in reliance upon it, through written notice sent to Medical Records Department 7232 Justin Way, Mentor, OH 44060 or by submitting a revocation request through your MyChart account.

_____
Parent/Court-Appointed Guardian's Name (Print)

_____
Parent/Court Appointment Guardian's Telephone Number #

_____
Parent/Court-Appointed Guardian's E-mail

_____
Signature of Patient's Parent/Court-Appointed Guardian

_____
Date

This form can be submitted by:

- ☐ Fax: (440) 269-2551
- ☐ Email: sh-medicalrecords@shinc.org
- ☐ Mail: 7232 Justin Way
  Mentor, OH 44060
- ☐ In-person: At any of our Signature Health Locations