GUNDERSEN
HEALTH SYSTEM

MyCare Minor Proxy Authorization Form (12 – 17 yrs old)

1900 South Avenue, AVS-001, La Crosse, WI 54601
PHONE: (800) 362-9567, Ext. 50303 or (608) 775-0303 ● **FAX:** (608) 775-0763
EMAIL: mycare@gundersenhealth.org

Patient Name:_____ Date of Birth:_____

Patient Address:_____ Phone Number: (___)_____

City/State/Zip:_____

I understand that MyCare is an Internet application that supports patient access to portions of my electronic healthcare record, electronic communications and other online services. I understand that MyCare is **NOT** to be used in an emergency.

I understand that certain medical information is protected by state and/or federal law, therefore my authorization is required before access can be granted to my information. This information includes, but is not limited to, mental health, substance abuse, HIV, STIs (Sexually Transmitted Infections) and reproductive information. I This authorization permits access to any care provided prior to the date of the authorization, as well as any care and treatment provided while the authorization is valid. I understand that the proxy will have access to the following information; this may include, but is not limited to:

- Laboratory results (that have been released based on my provider's discretion)
- Ability to communicate to my provider's care team regarding care and treatment through MyCare
- Ability to review and request appointments
- Request renewals on my prescriptions
- View summary information about my medical history

The reason for this access authorization is for the proxy to play a more active role in my healthcare. I understand that additional information may be made available to my proxy through MyCare as this application advances.

I understand that all activities within MyCare are tracked and messages my proxy makes shall become part of my permanent medical record.

I understand that by signing this form I am providing Gundersen Health System documentation of my authorization to provide proxy access to MyCare. I understand that I may revoke this authorization at any time, in writing.

I understand that MyCare is optional/voluntary and that my provider has the right to deactivate access to MyCare for unauthorized or inappropriate actions made by my proxy.

Having read this authorization, I hereby agree to abide by the terms of this agreement and grant minor proxy access to my personal health information via MyCare to the individual named below.

Proxy Name/Relationship:_____ Proxy Date of Birth:_____

Proxy Address:_____ Proxy Phone Number: (___)_____

City/State/Zip:_____

I understand that this authorization will expire when I turn 18 years old, unless otherwise revoked.

Signature of Minor Patient:_____ **Date**: _____

Signature of Parent/Legal Guardian:_____ **Date**: _____

_____
(If signed by authorized person, state relationship and authority to do so.)