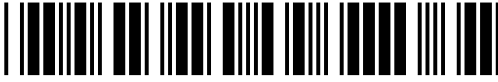
Stanford Children's Health | Lucile Packard Children's Hospital Stanford

Lucille Salter Packard Children's Hospital
STANFORD UNIVERSITY MEDICAL CENTER ● 725 Welch Road, Palo Alto, CA 94304



CONSENT • MYCHART TEEN ACCOUNT FORM

Medical Record Number

Patient Name

Addressograph Stamp

MyChart Teen Account Form

Parent/Guardian Authorizing Teen to Have MyChart Account

This form should be completed by the parent / guardian of a patient (age 12 - 17 years old) acknowledging and approving enhanced patient access to the patient's medical information electronically through MyChart.

I am requesting that the patient below receive access to his or her health information that is available in Stanford Children's MyChart record. I acknowledge Stanford Children's Health will release a portion of his or her health information contained in MyChart to this account. I understand that the medical information in MyChart is obtained from his/her electronic medical record and may include information from all facilities listed in the Stanford Children's Health Notice of Privacy Practices. I approve the release of non-sensitive information contained in the MyChart medical record held by Stanford Children's Health and Lucile Packard Children's Hospital Stanford to this patient.

I approve the release of this information only through MyChart. This form does not permit release of medical record information to the patient by other methods or in other forms (such as paper or CD/DVD/flash drive).

I understand that once information has been released to the patient through MyChart, he or she may potentially disclose or share the information in ways that may not be covered by federal privacy protections.

Participation in MyChart is completely voluntary. I also understand that the health care treatment or other services Stanford Children's provides is not affected by my decision to provide this acknowledgement or approval.

I understand that this acknowledgement and approval expires on the patient's eighteenth birthday or upon my written notice to Stanford Children's Health to terminate the patient's account access.

This Form is acknowledgement and approval that will permit Stanford Children's Health to electronically release a portion of the patient's information to him or her. Please read it carefully.

Please print legibly and complete all fields to ensure timely processing.

Patient Name (12-17 years old) ______________________________ ______________________________
Last First MI

Medical Record Number (MRN): ______________________________ Date of Birth ________________

Email address: ____

Phone: (________) ___________________________________

____ ______________________________
Signature of Parent (or authorized person, e.g. guardian) and attach documentation | Date

FACILITY USE ONLY

Date Request Received: Patient Relationship Verified By: ______________________________

Patient Access Approved ☐Yes ☐No Letter Sent: ☐Yes ☐No Date Sent: