FORM B

SPARTANBURG REGIONAL HEALTHCARE SYSTEM

PARENT OR COURT-APPOINTED GUARDIAN REQUEST FOR MYCHART PROXY ACCESS AUTHORIZATION FORM

MINOR PATIENT

Please print, fill out and return all Proxy Access forms to the patient's designated physician practice.

Patient's Name: _____

Patient's Telephone #:_____

Patient's Date of Birth (mm/dd/yyyy): _____

Patient's Current Street Address:

_____

_____

City State Zip Code

REQUEST FROM PARENT OR COURT-APPOINTED GUARDIAN OF THE PERSON

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 minor 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 minor patient's court-appointed guardian of the person.*

For the purposes of this form, "you," "your," "my," "me," and "I" mean the parent or court-appointed guardian listed below who is requesting and authorizing MyChart Proxy Access. As the patient's parent or court-appointed guardian of the person, I hereby authorize SRHS to release to me via SRHS MyChart Proxy Access any and all health information contained in the SRHS MyChart account of the above-named patient for any purpose that I deem to be appropriate, according to the SRHS MyChart Proxy 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 SRHS 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 SRHS MyChart Proxy 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 request to designate a MyChart Proxy.

I understand and agree that I must provide written notice sent to the designated physician practice if I am no longer the above-named patient's parent or 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 on the patient's eighteenth (18th) birthday, if the physician practice receives notice and documentation that I am no longer the patient's court-appointed guardian of the person (if applicable), if the physician practice 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, when the patient's SRHS MyChart account is deactivated 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 the designated physician practice.

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

_____
Parent/Court-Appointed Guardian's Email

_____
Parent/Court-Appointed Guardian's DOB

_____
Parent/Court-Appointed Guardian's Telephone Number

_____
Parent/Court-Appointed Guardian's Gender

_____
Parent/Court-Appointed Guardian's Address

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

_____
Date

Revised 11/04/2016