SPARTANBURG
Regional Healthcare System

My Chart Proxy Minor Patient Access Invitation

Granting someone access to your child's interactive health record

Parents can invite other adults to have access to their children's MyChart record. The birth or adoptive parent or legal guardian must be the one to initiate this invitation. To grant access to your child's interactive health record to another adult, please complete both pages of this form and return it via one of the methods on Page 2.

Patient Information

Name:_____ First Name:_____ MI:_____

Last 4 digits SSN: _____ Date of birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____

If this request is for a minor, please note you will no longer have access to this interactive health record once the dependent reaches the age of 18.

Invitee Information (to be completed for the other adult – all sections required)

Last Name:_____ First Name:_____ MI:_____

Last 4 digits SSN: _____ Date of birth: _____

Gender: _____ Street address: _____

City: _____ State: _____ Zip: _____

Email address: _____ Phone number: _____

Relationship to Patient: ☐ Stepparent ☐ Grandparent ☐ Other: _____

Parent/Guardian Information (to be completed with your info – all sections required)

Last Name:_____ First Name:_____ MI:_____

Last 4 digits SSN: _____ Date of birth: _____

Gender: _____ Street address: _____

City: _____ State: _____ Zip: _____

Email address: _____ Phone number: _____

Relationship to Patient: ☐ Father ☐ Mother ☐ Adoptive parent / Legal guardian*

**If legal guardian or adoptive parent, please submit proof of guardianship with this form.*

▶ *continued on page 2 – parent/guardian signature required*

Spartanburg Regional terms and agreement

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 on behalf of the "Invitee" listed above. As the patient's parent or court-appointed guardian, I hereby authorize SRHS to release to the Invitee via SRHS MyChart Proxy Access any and all health information contained in the SRHS MyChart account of the above-named patient for any purpose, according to the SRHS MyChart Proxy Terms and Conditions, which will allow the Invitee 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 of 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, 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 the Invitee's 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/Guardian Signature | Print Name | Date

How to submit this form

If the party you are granting access is not a patient of Spartanburg Regional Healthcare System or any of its physician practices or locations, they must first create a Spartanburg Regional MyChart account before they can receive access to your child's account. Visit Go.SRHS.com/MyChart for more information.

You can request proxy access by filling out the appropriate form(s) and:

- **In person:** Return form (with documentation, if applicable) to the appropriate physician office
- **Fax:** Fax form (with documentation, if applicable) to (864) 560-9112
- **Email:** Scan and email form (with documentation, if applicable) to HIMPROXY@srhs.com
- **Mail:** Return form (with documentation, if applicable) to:

  HIM Proxy
  Spartanburg Medical Center 101 E
  Wood St
  Spartanburg, SC 29303

NOTE: Signature on form must be done with a pen. Virtual/digital signatures will not be accepted.