Group Health Cooperative of South Central Wisconsin

Consent for Adult Access to a Minor's (0-17) GHCMyChart℠

Minor Patient Information (one form per minor)**:**

PATIENT NAME:	PATIENT MEMBER NUMBER (MRN):	PATIENT DATE OF BIRTH:
PATIENT STREET ADDRESS:		CITY/STATE/ZIP

Parent or Legal Guardian's Information:

PARENT or LEGAL GUARDIAN NAME	PARENT or LEGAL GUARDIAN DATE OF BIRTH
STREET ADDRESS	CITY/STATE/ZIP
PARENT or LEGAL GUARDIAN E-MAIL	PARENT OR LEGAL GUARDIAN PHONE NUMBER

Proxy's Information: (Please provide information for the Proxy who is to gain access to minor's GHCMyChart℠).

PROXY NAME	PROXY DATE OF BIRTH
STREET ADDRESS	CITY/STATE/ZIP
PROXY E-MAIL	PROXY PHONE NUMBER
PROXY SSN LAST 4: (Only required with submissions to HIM)	PROXY RELATIONSHIP TO CHILD

I, the legal guardian of the Minor Patient named above, authorize and agree that the above-named adult Proxy may have access to the Minor Patient's GHCMyChart℠ account.

- If the minor is age 0-17, this individual will be granted full proxy access to the minor's MyChart record. You may contact GHC-SCW Release of Information Department to have it revoked at any time.
- Once the minor reaches age 18, they will have full access to their GHCMyChart℠ record. Proxy access will automatically terminate, and this individual will no longer have access to the account.

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Parent or Legal Guardian's Signature (required) Date

Return form to GHC-SCW Release of Information at:

- Via email to: GHCROI@ghcscw.com
- Via fax to: (608) 441-3499
- Via mail to: Group Health Cooperative of South Central Wisconsin (GHC-SCW)
ATTN: Release of Information
1265 John Q Hammons Drive
Madison, WI 53717-1962