



## Minor Proxy Form (Age 17 and Under)

- I understand that MyVHP is not to be used for medical emergencies or urgent situations.
- I understand that MyVHP Proxy provides access to personal health information regarding the child or children 17 years of age and under listed on this form.
- The information disclosed in MyVHP will allow me to play a more active role in the healthcare of the child. I understand this is not the child's complete record, though an electronic or paper copy may be requested at the physician's practice.
- I understand that my activities within MyVHP are tracked by computer audits and that entries I make may become part of the medical record of the child.
- I understand that a written request must be made to cancel or revoke this authorization and that any actions taken or access prior to cancellation was authorized by my signature and date on the "Minor Proxy Form."
- I understand that Valley Health Partners Community Health Center has the right to revoke access of MyVHP at any time for abusive use of the system. I understand that when the child turns 18 years old, my access to their MyVHP account will be automatically terminated and an Adult Proxy Form would be required at the consent of the 18 year old child.
- I understand that should my child become emancipated, my access to my child's medical records using MyVHP will be immediately terminated, and a new proxy access must be granted.

**I have read and understand the requirements and procedures for accessing a child's medical record information online as provided in this proxy consent form.**

**I certify that all of the information I have provided is correct. I hereby request access to my child's online medical record. I have provided Valley Health Partners Community Health Center with legal documentation providing I am the parent or legal guardian of the child whose health information I will be accessing through MyVHP.**

X \_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date (Month/Day/Year)

**Office Use Only**

Patient's Medical Record Number: \_\_\_\_\_

Proxy Accounts Linked     Form Scanned