LEHIGH VALLEY HOSPITAL
LEHIGH VALLEY HOSPITAL - POCONO
LEHIGH VALLEY HOSPITAL - HAZLETON
LEHIGH VALLEY HOSPITAL - SCHUYLKILL

0 0 1

PLACE PATIENT LABEL HERE

MINOR PROXY FORM (AGE 17 AND UNDER)

FILL OUT BOXES BELOW ONLY IF PATIENT LABEL IS NOT AVAILABLE

Name (Last, First)	MR #	DOB	Date	Time AM/PM

Proxy Information – Individual Requesting Access to:

☐ **MyLVHN Portal**
☐ **MyChart Bedside**

- **I understand that MyLVHN/MyChart Bedside are not to be used for medical emergencies or urgent situations.**
- I understand that MyLVHN Proxy provides access to personal health information regarding the child 17 years of age and under listed on this form.
- MyChart Bedside provides access to personal health information regarding the child 17 years of age and under listed on this form, while this child is hospitalized.
- The information disclosed in MyLVHN 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 MyLVHN/MyChart Bedside 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 the my signature and date on the "Minor Proxy Form."
- I understand that Lehigh Valley Health Network has the right to revoke access to MyLVHN/MyChart Bedside at any time for abusive use of the system. I understand that when the child turns 18 years old, my access to their MyLVHN/MyChart Bedside 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 MyLVHN/MyChart Bedside 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. Name of Child_____ Date of Birth_____
I have provided Lehigh Valley Health Network with legal documentation providing I am the parent or legal guardian of the child whose health information I will be accessing through MyLVHN/MyChart Bedside.

X _____ _____ _____
Signature of Parent/Guardian **Date (Month/Day/Year)** **Time**

Office Use Only

Patient's Medical Record Number:

☐ **Proxy Accounts Linked**

☐ **Form Scanned**