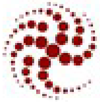

THE CENTER
ORTHOPEDIC & NEUROSURGICAL CARE & RESEARCH

MYCHART ACCESS AUTHORIZATION FOR MINOR PROXY

Minor / Child Information - *All fields are required.*
Complete one authorization per minor child less than 18 years of age.

Patient Name:______________________________ ☐ Male ☐ Female

Relationship to Parent / Guardian:______________________ DOB: ________ Age: ______

Parent / Guardian information - *All fields are required.*

Parent / Guardian Name:______________________________ DOB:________________

Address: ____________________________ Email Address:________________________

City, State, Zip: ________________________ Phone Number: ______________________

MyChart Terms and Conditions

I understand the following:

- MyChart contains selected, limited medical information from a patient's medical record and does not reflect the complete contents of the medical record.
- My activities within MyChart are tracked by computer audit, and entries I make can become part of my medical record or my minor child's medical record.
- My access to certain information about my minor child will be terminated upon my minor child's fourteenth birthday in accordance with Oregon state law. At this time, my teen minor will also be eligible to activate his / her own MyChart account.
- If my teen minor has special health care needs, my child's provider may authorize full access to his / her MyChart account if considered to be in his / her best interest.
- A reminder regarding any changes to my teen minor is MyChart account will be sent via message to the email listed on the proxy account 30 days in advance of the change. I understand I will receive the email notification and then will need to login to view the message.
- Mail OR email form to: MyChart Team, at 2200 NE Neff Road #200, Bend, OR 97701 mychart@thecenteroregon.com

Parent / Guardian signature:______________________________Date:______________

Parent / Guardian printed name:______________________________

If minor is between 14 and 17 years old, minor must acknowledge parent / guardian request for proxy access.
If the minor has questions as to what information is viewable, please call 541-322-2275

Minor signature (14 to 17 yrs. only):__________________________Date:______________

Minor printed name:______________________________

For Office Use Only
Document to be retained in Patient Record

Patient MRN:______________________________ Proxy Activation Date: ______________