Child proxy form

Access to your child's interactive health record

To sign up for access to your child's interactive health record, please complete both pages of this child proxy form and return it to the address shown below. Please note that your child's chart will be accessed through your Allina Health account. Completing this form will establish an Allina Health account for you and access to your child's interactive health record.

Return all forms to: Account Services or fax 612-262-1424
Mail Route 10607, 2925 Chicago Avenue, Minneapolis, MN 55407

Parent/guardian information: (all sections required – please print clearly)

Name *(last, first, middle initial)* _____

Last 4 digits SSN: _____ Date of birth: _____

Street address: _____ City: _____ State: _____ Zip: _____

Email address: _____ Phone number: _____

Check the box next to the organization that provides your primary care (select one):

- ☐ Allina Health
- ☐ Cuyuna Regional Medical Center
- ☐ FirstLight Health System
- ☐ Glencoe Regional Health Services
- ☐ Hutchinson Health
- ☐ River's Edge Hospital & Clinic
- ☐ Riverwood Healthcare Center
- ☐ St. Croix Regional Medical Center
- ☐ United Family Medicine
- ☐ The Urgency Room
- ☐ Western Wisconsin Health/Baldwin Area Medical Center

Please note the following age range limitations accessing a child's interactive health record. These age range limitations do not affect any legal right you have to access your child's health record by other means. To request a paper copy of your child's health record, contact your child's primary care clinic.

- **Age 0-12:** you will be granted full access to your child's interactive health record.
- **Age 13-17:** you will be granted partial access to your child's interactive health record (appointment scheduling, immunizations).
- **Age 18:** you will no longer have access to your child's interactive health record.

Child's information (all sections are required):

Please complete one form per child for whom you need proxy access. The child proxy form can be found on allinahealth.org

Name *(last, first, middle initial)* _____

Last 4 digits SSN: _____ Date of birth: _____

Check the box next to the organization that provides your primary care (select one):

- ☐ Allina Health
- ☐ Cuyuna Regional Medical Center
- ☐ FirstLight Health System
- ☐ Glencoe Regional Health Services
- ☐ Hutchinson Health
- ☐ River's Edge Hospital & Clinic
- ☐ Riverwood Healthcare Center
- ☐ St. Croix Regional Medical Center
- ☐ United Family Medicine
- ☐ The Urgency Room
- ☐ Western Wisconsin Health/Baldwin Area Medical Center

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

Allina Health terms and agreement

- I understand that my Allina Health account is intended as a secure online source of confidential health information. If I share my username and password with another person, that person may be able to view my or my child's health information, and health information of someone who has authorized me as a proxy.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe confidentiality may have been compromised in any way.
- I understand that it is my responsibility to ensure that my email address is current at all times, and that if my email address is not current I will not receive important messages from Allina Health.
- I understand that the interactive health record contains select, limited medical information from a patient's health record and that it does not reflect the complete contents of the health record. I also understand that a paper copy of a patient's health record may be requested.
- I understand that my activities within my Allina Health account may be tracked electronically and that entries I make may become part of the health record.
- I understand that access to the Allina Health account is provided as a convenience to patients and that Allina Health has the right to end access to my Allina Health account at any time, for any reason.
- I understand that my use of my Allina Health account is voluntary and I am not required to use my account or to authorize a proxy.

▶ _____

Signature of parent/authorized person *(required)* **Relationship to patient** **Date** *(required)*