



Patient Name: _____
 MRN: _____
 Date of Birth: _____
Complete above information or attach patient label to each page.

Minor Consent to Signup Form (Age 13-17)

Thank you for your interest in MyLGHealth. MyLGHealth is a secure patient portal that allows you to access parts of your medical record online.

MyLGHealth Terms and Agreement

- **I understand that MyLGHealth is NOT to be used in an emergency situation.**
- I understand that MyLGHealth is intended as a secure online source of confidential medical information. If I share my MyLGHealth ID and password with another person, that person may be able to view my or my child's health information.
- 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 it may have been compromised in any way.
- I understand that MyLGHealth contains select medical information from a patient's medical record and that MyLGHealth does not reflect the complete contents of the medical record. I also understand that a paper copy of a patient's medical record may be requested from the patient's practice.
- I understand that my activities within MyLGHealth may be tracked by computer audit and that entries I make may become part of the medical record.
- I understand that access to MyLGHealth is provided by Lancaster General Health as a convenience to its patients and that Lancaster General Health has the right to deactivate access to MyLGHealth at any time for any reason. I understand that use of MyLGHealth is voluntary and I am not required to use MyLGHealth or to authorize a MyLGHealth Proxy.

By signing below, I acknowledge that I have read and understand this MyLGHealth Minor Consent to Signup Form and I agree to its terms to abide by those conditions as long as the MyLGHealth account is active.

X _____ / _____
 Signature of Minor or Legally Authorized Representative Date Time

 Printed Name of Minor or Legally Authorized Representative

Legally Authorized Representative is consenting for minor patient, who is unable to consent because:

I (Parent Full Name) _____ have read and understand the requirements and procedures for my child to access their medical record information online as provided above.

X _____ / _____
 Co-signature of Parent / Guardian Date Time

 Printed Name of Parent / Guardian





Patient Name: _____
 MRN: _____
 Date of Birth: _____
Complete above information or attach patient label to each page.

Minor Consent to Signup Form (Age 13-17)

Please fill out all of the required information below in order to sign up for a MyLGHealth account. Once we have received this form we will send your access code via the United States Postal Service. Please allow ten business days from mailing this form for processing your request of an access code.

MINOR PATIENT - PLEASE PRINT ALL INFORMATION CLEARLY:

Full Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Email: _____
 Phone Number: (____) _____ Date of Birth: _____
 Primary Doctor's Office: _____
 Primary Care Physician: _____

Completed forms may be sent by the following methods:

1. **Scan and e-mail to:** LGLegalForms@lghealth.org
2. **Fax to:** 717-544-8884
3. **Mail to:** Health Information Management
 Attention: Document Imaging
 555 North Duke Street
 PO Box 3555
 Lancaster PA 17604-3555