

| 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 unde to its terms to abide by those conditions as long as the Myl | - | or Consent to Signu | ip Form and I agree |
|---|--------|---------------------|---------------------|
| X | | | |
| Signature of Minor or Legally Authorized Representative | | Date | Time |
| Printed Name of Minor or Legally Authorized Represent | tative | _ | |
| Legally Authorized Representative is consenting for minor patient, who is unable to consent because: | | | |
| | | | |
| I (Parent Full Name) and procedures for my child to access their medical record | | | the requirements |
| X | | | |
| Co-signature of Parent / Guardian | | Date | Time |
| Printed Name of Parent / Guardian | | _ | |





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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 | 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

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