



Patient Name: _____

MRN: _____

Date of Birth: _____

Complete above information or attach patient label to each page.

Minor Proxy Form (Age 12 and Under)

MyLGHealth Terms and Agreement

- **I understand that MyLGHealth is NOT to be used in an emergency.**
- I understand that MyLGHealth Proxy provides access to personal health information regarding my child or children 12 years of age and under listed on this form.
- The information disclosed in MyLGHealth will allow me to play a more active role in the healthcare of my child. I understand this is not the child's complete record, though a paper copy may be obtained at the physician's practice.
- I understand that my activities within MyLGHealth are tracked by computer audits and that entries I make may become part of the medical record of my child. This excludes parent/legal guardian-entered notes that are viewable only by you.
- I understand that by signing this agreement, I am providing Lancaster General Health documentation of my authorization to access my child's protected health information. 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 were authorized by my signature and date on the "Minor Proxy Form (Age 12 and Under)"
- I understand that my child's healthcare provider has the right to de-activate access to MyLGHealth for unauthorized or inappropriate actions on my part. I understand that when my child turns 13 years old, my access to their MyLGHealth account will be automatically terminated, and new proxy access required at the consent of my child at age 18 and older.
- I understand that should my child become pregnant, or otherwise emancipated, my access to my child's medical records using MyLGHealth will be immediately terminated, and a new proxy access must be granted by my child.

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 that I have provided is correct. I hereby request access to my child's online medical record. I have provided Lancaster General Health with legal documentation proving I am the parent or legal guardian of the child whose health information I will be accessing through MyLGHealth.

X _____
 Signature of Parent / Legal Guardian

 Date Time

 Printed Name of Parent / Legal Guardian





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Minor Proxy Form (Age 12 and Under)

Please fill out all of the required information below in order to have the proxy access created.

Parent / Legal Guardian Information - PLEASE PRINT ALL INFORMATION CLEARLY

Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (____) _____

Date of Birth: _____

Email: _____

Relationship to Child: Mother Father Legal Guardian

Please fill out all of the requested information below for each child. This information is required to setup the proxy account between the parent / legal guardian and the child.

Full Name: _____

Address: _____

(If different from Parent / Legal Guardian Address)

Phone Number: (____) _____ Date of Birth: _____ Gender: Male Female

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

Office Use Only

Parent / Legal Guardian's Medical Record #: _____

Proxy Accounts Linked

Form Scanned