ELLIOT HEALTH SYSTEM
MyEChart Parent / Guardian Access Form

You must complete and sign this form to establish access to the MyEChart account of your child, or the account of another individual for whom you are the lawful caregiver. Elliot Health System's policies regarding parental/guardian access to MyEChart are enforced to comply with laws that affirm the rights of child patients who may seek confidential diagnosis and treatment for certain health conditions.

The level of parental/guardian access to a child's account will change automatically as the child reaches certain ages. For patients under the age of 12, parents/guardians are permitted full access and control of the child's MyEChart account. Children under the age of 12 are not authorized to access the account.

For patients between the ages of 12 and 18 years, full access to MyEChart will be provided to the individual. For parents/guardians of patients between the ages of 12 and 18 years, access to MyEChart is permitted, but specific information will be restricted. For example, parental/guardian access will be limited to emailing your child's doctor. In addition, the parent/guardian will be permitted to access only certain information, such as patient-entered flow sheets, health reminders, and allergies, however full access to the patient's record will not be authorized.

For patients 18 years and older, the patient will have full access and control of the account. Parental/guardian access to the account will be terminated unless continued access would be appropriate based on special circumstances.

Before completing this form, please carefully read the MyEChart access terms above.

I am requesting MyEChart access to the account of:

☐ **My child** ☐ **An individual for whom I am a legal caregiver**
(*This request must be accompanied by documentation verifying the authority of the patient's personal representative.*)

Patient Information:

Patient Name: ____________________
Date of Birth: ____________________
Elliot #: ____________________
Telephone #: ____________________
Address: ____________________
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Requestor Information:

Requestor Name: ____________________
Date of Birth: ____________________
Email: ____________________
Telephone #: ____________________
Address: ____________________
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I have read and understand the requirements and policies for accessing MyEChart. I certify that I am the parent or legal guardian of the child listed above, and that all information I have provided is correct.

SIGNED:____________________ DATE:____________________
Parent or Legal Guardian

PLEASE MAIL COMPLETED AND SIGNED FORMS TO:
ELLIOT HOSPITAL
ATTN: MEDICAL RECORDS ROI
ONE ELLIOT WAY
MANCHESTER, NH 03103