

1. Parent / Guardian Information:

Parent / Guardian Name (Last, First, Middle Initial): _____
 Social Security Number: _____ Date of Birth: _____
 Street Address: _____ City: _____ State: _____ Zip: _____
 E-mail Address: _____ Phone Number: _____

2. Minor for Whom Access is Requested and Relationship to Minor

Minor:
 Name (Last, First, Middle Initial): _____ Date of Birth: _____
 Address: Same as Parent Above
 Street Address: _____ City: _____ State: _____ Zip: _____
 Patient's Email Address: _____
 Please check box that applies:
 Parent (Married to Other Parent of Minor or Never Married with all Legal Rights)
 Legal Guardian
 Divorced or Unmarried Parent with Sole / Shared Parental Responsibility
 Power of Attorney for Healthcare

3. Authorization for Release of Information in Lee Health MyChart (Minor Section):

NOTE: If both parent or legal guardian and minor child do not give mutual consent to both parties having MyChart Access, then neither party will be granted access.

I _____ (Patient Name) hereby authorize the use or disclosure of my protected health information. I understand that this authorization is voluntary and I may refuse to sign it.

The purpose of this release is to allow the Authorized User above access to my entire Lee Health & Community Connect Partners MyChart account and all protected health information and other information contained therein.

I understand that Lee Health, and its Affiliated Covered Entities, and Community Partners will not condition treatment, payment, enrollment or eligibility of benefits on the completion of this Authorization.

I understand that the information in my Lee Health, and its Affiliated Covered Entities, and Community Partners MyChart health record may include information relating to sexually transmitted disease, pregnancy, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal and/or state confidentiality rules.

I understand that I have the ability to revoke this Authorization at any time through my Lee Health, and its Affiliated Covered Entities, and Community Partners MyChart account or by providing written notice to the Privacy Officer at Compliance Department - P.O. Box 2218, Fort Myers, FL 33902. My revocation will be effective upon receipt, but will not have any effect on prior actions taken in reliance upon this Authorization.

I understand this Authorization will be revoked on my 18th birthday, unless I choose to revoke earlier.

I and my successors or assigns hereby hold Lee Health, and its Affiliated Covered Entities, its affiliates, employees, representatives, agents, officers, Board of Directors, volunteers and any other person participating in my care and their successors and assigns harmless from any and all liability including claims for libel or invasion of privacy, directly or indirectly connected with, arising out of, or resulting from the taking and authorized use my information in Lee Health MyChart.

I understand this authorization must be filled out completely, signed and dated in order to be considered valid.

Signature of Minor Patient

Date/Time

Printed Name of Minor Patient

4. Required Documentation (Parental Section):

If you are the Legal Guardian, a Divorced Parent with Sole or Shared Parental Custody, have a Power of Attorney for Healthcare for the minor or other documentation which would allow you access to the minor's medical information, you may be requested to provide Lee Health a copy of the legal document with this request for parental access. I certify that I have not had my legal rights to the requested medical records restricted by any Court Order.

I understand that when the minor turns 18 years old, parental access to MyChart will be terminated.

I grant permission for my minor child to have access to their own Lee Health MyChart Health Record. I understand that my minor child may revoke my parental access at any time for any reason.

Signature of Parent / Authorized User

Date/Time

Printed Name of Parent / Authorized User