

**SHANNON HEALTH SYSTEM**

**MyChart Patient Assent Agreement**

**For Patients between 14-17 years of age**

By signing below, I grant my parent(s) or legal guardian(s) access to my medical records which are maintained by Shannon Health in the MyChart online portal. I understand such records may include private information or sensitive test results from my visits to Shannon Clinic physicians (for example, prescribed birth control medication).

I understand that I can make changes to or cancel this permission by a) calling 325-657-5198, or b) sending an email to: [PrivacyOfficer@shannonhealth.org](mailto:PrivacyOfficer@shannonhealth.org).

I understand when I turn 18 years of age, access for my parent(s) or legal guardian(s) will end unless I re-send a new proxy access request.

I understand that if my parents are divorced, both custodial and non-custodial parents may have access to MyChart and both parents are listed below.

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Printed name of parent or legal guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of parent or legal guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Date of Birth