Parental Access to the Online Medical Record of an Adolescent (Ages 12-17)

I understand that MyPrevea is for access to personal health information regarding my child between the ages of 12-17. I understand that MyPrevea is NOT to be used in an emergency.

I understand that it is my responsibility to maintain my password in a secure manner and to change it if I feel that it has been compromised in any way.

I understand that I am only allowed to access limited information and medical records for my child.

This information disclosed in MyPrevea will allow me to play a more active role in the health care of my child. I understand that additional information may be made available to me as MyPrevea continues to evolve.

I understand that my activities within MyPrevea.com are tracked by computer audits and that entries I make will become part of the medical record of my child.

I understand that by signing this agreement, I am providing Prevea documentation of my authorization to access my child's protected health information as described above. 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 "Authorization Form for an Adolescent (Ages 12-17) to the Online Medical Record of a Child."

I understand that my child's health care provider has the right to de-activate access to MyPrevea for unauthorized or inappropriate actions on my part. I understand that when my child turns 18 years old, my access to MyPrevea account will be automatically terminated.

By signing the ""Authorization Form for an Adolescent (Ages 12-17) to the Online Medical Record of a Child," I am acknowledging that I understand the disclosure of my child's protected health information by me for my use. I also certify that I am the parent or legal guardian of the child on the authorization form and that the information I have provided is correct.

P.O. Box 19070, Green Bay, Wisconsin 54307-9070
(920) 496-4700 ■(888) 2PREVEA ■www.prevea.com

Authorization Form for **Parental Access** to the Online Medical Record of an Adolescent (Ages 12-17)

Child's name: _____

Child's address:_____ Date of Birth:_____

_____ Male:_____ Female:_____

E-mail address for MyPrevea messages about this child's medical care:

_____

Birth parent/legal guardian information (access to a child's online medical record is available only to birth parents or individuals with legal guardianship)

Name:_____

Address:_____ Date of Birth:_____

_____ Male:_____ Female:_____

Former name(s), e.g. maiden name:_____

Relationship to child: Birth parent_____ Adoptive parent____ Legal guardian:____ Other:____

If other, please specify:_____

Do you have an active MyPrevea account? Yes_____ No_____ Unsure_____

You must have a MyPrevea account to access your child's medical record. If you do not have a MyPrevea account, you must complete and submit the Authorization Form for Personal Access along with this form.

I have read and understand the requirements and procedures for accessing my child's medical record information online as provided in the document "Parental Access to the Online Medical Record of an Adolescent (Ages 12-17)"

I certify that I am the birth parent or legal guardian of the child listed above and that all of the information that I have provided is correct. I hereby request access to my child's medical record.

_____ _____

Date Birth parent/Legal guardian signature

Please complete, sign and return this form to any Prevea Health Center or to:
Prevea Health
Attn: MyPrevea Help Desk
P.O. Box 19070
Green Bay, WI 54307-9070

You may also fax this form to (920)-431-3128

*For office use only: send to Scanning

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