Nebraska Medicine

TEENPX

PT NAME

MR #

The provider for the minor patient named below has recommended that this child have access to the patient portal to more fully participate in his/her healthcare.

PATIENT INFORMATION		
PATIENT NAME: LAST, FIRST, MIDDLE INITIAL	PATIENT EMAIL ADDRESS	
PATIENT STREET ADDRESS	PATIENT PHONE NUMBER	
CITY	STATE	ZIP
LAST FOUR NUMBERS OF SSN OF PATIENT	PATIENT DATE OF BIRTH	PRIMARY CLINIC

Parent or Legal Guardian Authorization

- **By signing below, I am certifying to the fact that I am the legal parent or guardian of the above named patient and have all right and authority to allow access to his/her medical information.**
- I understand that One Chart | Patient contains selected, limited medical information from a patient's medical record and that One Chart | Patient does not reflect the complete contents of the above named patient's medical record.
- I understand that I may separately request proxy access to the above named patient's One Chart | Patient account, but that the extent of my access will not be exactly the same as the above named patient's access.
- I understand that a paper copy of the patient's medical record may be requested from the Health Information Management department.
- I understand that access to One Chart | Patient is intended for the above named patient's personal and private use and engagement with his/her healthcare provider(s).
- I understand that One Chart | Patient may include recorded family history (which includes but is not limited to mental health history and all available biological and/or adoptive information) and the results of laboratory tests (including the results of any completed genetics and other sensitive tests). I understand that it may be beneficial for the above named child to discuss some of this information in advance of granting access to One Chart | Patient.
- I understand that I may seek more information from the above named patient's provider before I make a decision to authorize his/her access to One Chart | Patient.
- I understand that if the above named patient's decision making capacity or my legal authority with respect to the patient changes that I need to submit documentation to his/her healthcare provider(s).

Signature of Parent/Legal Representative _____ Date _____

Questions can be directed to: Nebraska Medicine, One Chart | Patient Support Desk, 402-559-0700. Requests for medical records or other communication with the Health Information Management Department can be sent by email (HIMproxy@nebraskamed.com), fax (402-559-1340) or by mail to: Nebraska Medicine, Health Information Management Department, 989100 Nebraska Medicine, Omaha, NE 68134-9100.