Print

Consent - Proxy Auth

Saint Luke's

Parental/Guardian Proxy Access to the mySaintLuke's Portal Record of a Minor
Parental/Guardian Authorization Form

Please enter **Patient's (Child)** information:

Patient's Name:_____ Medical Record #:_____ (if known)

Address:_____ Last four digits of Social Security #:_____

_____ Date of Birth:_____

Gender: ☐ Male ☐ Female

Please enter **Parent/Legal Guardian** information:

Parent Name:_____ Email Address:_____

Address:_____ Last Four Digits of Social Security #:_____

_____ Date of Birth:_____

Phone Number:_____ Gender: ☐ Male ☐ Female

Relationship to child: ☐ Birth Parent ☐ Adoptive Parent ☐ Legal Guardian ☐ Other

If Other, please specify:_____

Note: Access to a minor child's online portal record is only available to parents or individuals with legal guardianship. Appropriate documentation on legal relationship to child must be provided when requested. Saint Luke's can revoke access to the online portal record at any time. Parents/legal guardians are always allowed to access their child's full medical record as allowed by law, through the HIM department.

"I acknowledge the following *(initial each)*:

_____ I have read and understand the requirements and procedures for accessing my child's medical record information online as provided on page one of this document.

_____ I will not share my mySaintLuke's User ID and Password with others.

_____ Information and alerts regarding mySaintLuke's will be sent to me at the email address provided. If no email address is provided, information and alerts will be sent to me via mail at the address provided.

_____ I agree to abide by the terms and conditions of the mySaintLuke's site.

_____ When my child turns 12 years old, my access to the mySaintLuke's account will be limited. When my child turns 18 years old, my access to the mySaintLuke's account will be automatically terminated.

_____ **I certify that I am the parent or legal guardian of the minor child listed above and that all information I have provided is correct. I hereby request access to my child's online portal record."**

_____

Parent/Legal Guardian Signature **Date** **Time**

RETURN FORM TO FRONT DESK AT ANY CLINIC/OFFICE or A HOSPITAL REGISTRATION AREA
If supporting documentation is requested, it may be emailed to kcproxyrequest@bjc.org

While it is unlikely, there is a possibility that unsecure email could be intercepted and read by other parties besides the person to whom it is addressed. By sending your request by email, you agree to accept these risks.

STAFF: Original - email to kcproxyrequest@bjc.org, fax to HIM at 816-891-6072, or interoffice mail to SLN – HIM MSL Team
Copy to patient/guardian