Lifespan
Delivering health with care.

MyLifespan Teenager Sign-Up Form & Authorization

To the Parent/Guardian Permitting Access by the Teenager:

Thank you for your and your teenager's interest in *MyLifespan*, an easy-to-use Internet tool. *MyLifespan* can provide your teenager with quick and secure online access to his or her healthcare information from Lifespan affiliates and their health care professionals, **and** your teenager's doctors who are partnering with Lifespan hospitals and affiliates to offer *MyLifespan* to your teenager. If you sign this form, you agree to give your teenager private access to his or her health care information contained in *MyLifespan*. Clinicians generally agree that providing teenagers with some control over their medical records encourages them to speak openly and honestly with their caregivers and promotes better health outcomes and increased maturity. If you decide to give your teenager control over his or her *MyLifespan* record, he or she will have the opportunity to decide whether to share access with you by giving you proxy access to the *MyLifespan* account. If your teenager does not grant you proxy access, you will still have a limited view of information such as billing, scheduling, allergies and non-sensitive lab results. Restrictions applicable to your teenager's *MyLifespan* account do not affect any legal right you might have to access his or her records by other means.

Instructions to the Parent/Guardian for Completing this Form

To sign up your teenager for access to his or her health information in *MyLifespan*, please complete this Sign-Up Form with your teenager and return it to the address shown below. If you would also like access to the *MyLifespan* information of another adult or your child under the age of 13, please ask your clinic for the appropriate forms.

Your Teenager's Information: (All sections required – please print clearly.)

Last Name _____ First Name _____ Middle Initial ___
Social Security Number: _____ Date of Birth: _____
Street Address: _____ City:_____ State: _____ Zip: _____
Email Address: _____ Phone Number: _____
Primary Care Physician/ Clinic: _____

Your Information: (All sections required – please print clearly.)

Last Name _____ First Name _____ Middle Initial ___
Do you have a MyLifespan Account? ☐ Yes ☐ No. If "no," please complete the following:
Social Security Number: _____ Date of Birth: _____
Street Address: _____ City:_____ State: _____ Zip: _____
Email Address: _____ Phone Number: _____

Sign-Up Agreement
Completed by Parent/Guardian for Teenager (ages 13-17)
Participation in *MyLifespan* Patient Portal

I, the parent/guardian for my teenager named above, request that my teenager have access to his or her online medical record.

BY SIGNING BELOW, I ACKNOWLEDGE AND AGREE:

- I understand and have explained to my teenager that *MyLifespan* is intended as a secure online source of confidential medical information. If my teenager shares his or her *MyLifespan* ID and password with another person, that person may be able to view my teenager's health information.
- I agree that it is my responsibility to ensure that my teenager selects a confidential password, maintains the password in a secure manner, and changes the password if I or my teenager believes it may have been compromised in any way.
- I understand and have explained to my teenager that *MyLifespan* should never be used for emergencies or urgent health matters, and that FOR ALL MEDICAL EMERGENCIES, I SHOULD IMMEDIATELY DIAL 911.
- I understand that *MyLifespan* contains selected, limited medical information about my teenager's medical record and that *MyLifespan* does not reflect the complete contents of their medical record.
- I understand that my teenager's activities within *MyLifespan* may be tracked by computer audit and that entries they make may become part of the medical record.
- I understand that access to *MyLifespan* is provided by Lifespan affiliates and its partners as a convenience to their patients, and that Lifespan affiliates and/or partners reserve the right to deactivate my teenager's access to *MyLifespan* at any time for any reason with or without any prior notice. By signing below, I consent to having my teenager's medical records made available through the *MyLifespan* web portal, and agree to the terms of *MyLifespan* User Agreement available through *MyLifespan* web portal.
- By signing below, on behalf of my teenager, I acknowledge that I have read and understand this *MyLifespan* Sign-Up Form and I agree to its terms.
- That all of the information provided is correct and that I am the parent or legal guardian of the teenage patient named above.
- That I agree on behalf of myself and my teenager to waive and release the teenager's physician, Lifespan and its affiliated entities, and their officers, directors, employees, agents, successors and assigns from any and all claims or causes of action that are in any way related to my teenager's use of *MyLifespan*.
- That I understand that my teenager can revoke my access to all of his/her information at any time and when my teenager turns 18, I and/or the parent/guardian will no longer have access to any of his/her information.

Signature of Parent/Guardian/Authorized Person / **Relationship to Patient** / **Date** *(Required)*

Optional **Proxy Authorization for Release of Teenager Medical Information**

(To be completed by teenager who wants to allow a parent shared access to his or her *MyLifespan* account)

This form is an authorization that will permit Lifespan affiliates and their health care professionals, **and** your doctors (who are partnering with Lifespan hospitals and affiliates to offer MyLifespan) to release your (teenager) medical information to your parent(s) if you complete this form and sign below.

Even though you are under age 18 and do not have the legal right to make medical decisions, your parent or guardian has agreed to allow you to set up a *MyLifespan* account so that you can view many of your health care records and begin to get involved in your own health care. Because your parent has given you this right, you now have the right to make a decision about whether you want to share access to your on-line account with your parent(s). You have the right to say no, and if you do, your parent will only be able to view a limited amount of your health information (such as billing/scheduling/allergies) on-line through your *MyLifespan account.* If you want to say no, you should not sign this form. However, even if you say no, your parent might still have the right to view your complete records by other means.

If you do decide to let your parent share access to your *MyLifespan* account, Lifespan will try to restrict access to the following categories of information: HIV/AIDS, communicable diseases, abortion, substance abuse, transgender services, family planning, or other information related to reproductive care; however, it may not always be possible for Lifespan to do so.

Any access you decide to give your parent will automatically terminate once you turn 18.

PLEASE READ THIS FORM CAREFULLY BEFORE MAKING A DECISION.

Patient (Teenager) Name_____
(last, first, middle initial)

I am requesting that my proxy_____*(print full name of parent(s) or guardian)* receive access to my health information that is available in my/patient's *MyLifespan* record. This person is my designated *MyLifespan* proxy. I authorize the Lifespan Corporation, its affiliate hospitals and the providers who are partnering with Lifespan hospitals and affiliates to release the medical information contained in *MyLifespan* record to *MyLifespan* proxy. I understand that the medical information in *MyLifespan* is obtained from my electronic medical record. Such medical information may include but not be limited to *current or past medications, allergies, recent diagnoses (problems), laboratory test results, diagnostic tests such as toxicology screens), radiology and pathology reports*. I authorize the release of any information contained in my *MyLifespan* record to my designated proxy, including sensitive medical information that would otherwise be subject to special restrictions on disclosure *such as HIV/AIDS, behavioral health, communicable diseases, abortion, substance abuse, transgender services, family planning, or other information related to reproductive care*.

I understand that once information has been disclosed, it potentially may be re-disclosed by the proxy and the disclosed information may not be covered by the same federal and/or state privacy protections.

Participation in *MyLifespan* and designating a *MyLifespan* proxy is completely voluntary. I understand that I am not required to designate a *MyLifespan* proxy and I am not required to provide this authorization. I also understand that Lifespan, its affiliated hospitals and the providers who are partnering with Lifespan hospitals and affiliates do not condition any of my health care treatment, payment or other services on whether I provide this authorization. However, I also understand that if I do not provide authorization, Lifespan, its affiliated hospitals and the providers who are partnering with Lifespan hospitals and affiliates are not permitted to give access to *MyLifespan* record to my designated proxy.

This authorization will be effective until I turn 18, or until terminated by you. You may terminate this authorization at any time by revoking proxy access through your *MyLifespan* record or by providing a written request for revocation/cancellation to the <**Hospital name**>, <**Full Address**>. I understand that if I revoke or cancel this authorization, my designated proxy's access to my *MyLifespan* record will end. I also understand my revocation/cancellation will not affect any disclosures that were made prior to processing the revocation.

Date:_____Primary Clinic:_____

Signature of Minor Patient: _____

Printed Name:_____