FAMILY HEALTH CENTERS AT NYU LANGONE

SBHC Contact Information:
Long Island City High School
14-30 Broadway Room 546
Queens, NY 11106
Telephone: (718) 545-7683 x5468

It's fast and easy for your child to receive health care services through the School-Based Health Center!

Dear Parent or Guardian:

We are happy to inform you that your **high school** has a School-Based Health Center (SBHC)!The SBHC is staffed by licensed professionals from NYU Langone Family Health Centers. By signing the SBHC consent forms, you are not replacing your child's doctor but are giving permission for your child to receive **medical and/or behavioral health** if needed at the SBHC. Having a health center in your child's school allows for quick and easy access to quality services. We will work in collaboration with your child's primary health provider. Signing this consent **does not** change your insurance plan and does not affect the number of times your child can see their private doctor. If your child is covered by health insurance (Medicaid, Child Health Plus, or a commercial insurance plan) please provide us with the insurance ID number and the name of the insured. We will bill your insurance, but you will not be responsible for any copays.

School-Based Health Center Services include:

- Complete physical examinations;
- Medications and prescriptions;
- Medical laboratory tests; Immunizations
- Medical care, including treatment for acute and chronic conditions;
- Age appropriate reproductive health care
- Mental health services; Health Education and Counseling
- Screening for vision, hearing, asthma, obesity, and other medical conditions;
- Screening and referral for health insurance;
- Access to care 24 hours/day, 7 days/week
- Telemedicine Virtual Visits

In order for your child to receive health services, a parent or legal guardian must **read, complete, sign and return** the attached consent to the School-Based Health Center or email the completed consent to FHCschoolhealth@nyulangone.org

☺ Family Health Centers at NYU Langone SBHC Parental Consent Form

☺ Health History Form

We look forward to meeting you and providing health services for your child. Please visit us at the School-Based Health Center or call our School-Based Health Hotline **347-377-3170** for more information.

If you have already completed a NYU Langone School Based Health Center Parental Consent Form at your previous school, your child is automatically enrolled and can access our services immediately!

Sincerely,

Family Health Centers at NYU Langone SBHC Staff

August 2022

COPY FOR HS PARENTS

Family Health Centers at NYU Langone
School Based Health Center Parental Consent Form

Health Care Service Provider address: 14-30 Broadway Room 546 Queens, NY 11106
Name of School(s): *Long Island City High School*

Please know that your child can use the School-Based Health Center and see your other doctors.
Signing this consent does not change your insurance, does not change your private doctor, and does not affect the number of times your child can see their private doctor.

STUDENT INFORMATION

Student Last Name: _____
Student First Name: _____
Date of Birth: _____/_____/_____
Month Day Year
Student Address:_____
_____
City State Zip Code
Student email:_____

***Student Social Security Number:** _____
Sex: ❑ Male ❑ Female Grade _____

Ethnicity: ❑ Hispanic ❑ Black ❑ White ❑ American Indian ❑ Asian/Pacific Islander ❑ Other _____
List the student's regular doctor, if they have one?
Name: _____
Telephone: _____
Address: _____

Indicate the Pharmacy where we can send prescriptions.
Pharmacy_____
Pharmacy Address: _____
Pharmacy Tel: _____
***Indicates optional field: Used for insurance purposes only**

PARENT INFORMATION

Parent/ Legal Guardian:
Last Name: _____ First Name: _____
Home/Work Tel: _____
Cell Phone: _____
Email: _____

Parent/Legal Guardian:
Last Name: _____ First Name: _____
Home/ Work Tel:_____
Cell Phone:_____
Email :_____

If legal guardian , relationship to the student:
❑Grandparent ❑ Aunt/Uncle ❑Foster Parent ❑ Other: _____
Home /Work Tel: _____
Cell: _____
Email: _____
Preferred Language of Parent/ Guardian:_____

ADDITIONAL EMERGENCY CONTACT

Name: _____
Relationship to Student: _____
Home or Work Tel:_____
Cell: _____

INSURANCE INFORMATION

Does your child have Medicaid?
❑ No ❑ Yes: Medicaid ID # _____

Does your child have Child Health Plus?
❑ No ❑ Yes: CHP # _____

Which Plan?
❑ Affinity ❑ Fidelis
❑ Healthfirst ❑ Empire BC/BS Health Plus
❑ Emblem Health(HIP/GHI) ❑ Metro Plus
❑ WellCare ❑ United Healthcare

Does your child have other health insurance
❑ No ❑ Yes, Health Plan: _____
Member ID/Policy Number: _____
Health Insurance Phone: _____

If your child does not have health insurance, would you like a representative to contact you to assist with getting health insurance?
❑ No ❑ Yes What is the best time to contact you? _____

Box 1. PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES. Please sign Box 1 & 2

I have read and understand the services listed on the next page (School-Based Health Center Services) and my signature provides consent for my child to receive services provided by the Family Health Centers at NYU Langone (HCSP) School-Based Health Center. By law, parental consent is not required for the conduct of mandated screenings, the application of first aid treatment, prenatal care, services related to sexual behavior and pregnancy prevention, and the provision of services where the health of the student appears to be endangered. Parental consent is not required for students who are 18 years or older or for students who are parents, married or legally emancipated. My signature indicates I have received a copy of the Notice of Privacy Practices. My signature also gives my consent to contact other providers who have examined my child.

X _____ _____
Signature of Parent/Guardian **Date**

Box 2. HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information in Box 2 on reverse side of this form. My signature indicates my consent to release medical information as specified in the box 2 section only.

X _____ _____
Signature of Parent/Guardian **Date**

Family Health Centers at NYU Langone
School Based Health Center Parental Consent Form

SCHOOL BASED HEALTH CENTER SERVICES — BOX 1

I consent for my child to receive health care services provided by the State-licensed health professionals of Family Health Centers at NYU Langone (HCSP) as part of the school health program approved by the New York State Department of Health. I understand that confidentiality between the student and the health provider will be ensured in specific service areas in accordance with the law, and that pupils will be encouraged to involve their parents or guardians in counseling and medical care decisions. School-Based Health Center services may include, but are not limited to:

1. Mandated school health services, including: screening for vision (including eye glasses), hearing, asthma, obesity, scoliosis, Tuberculosis and other medical conditions, first aid, and required and recommended immunizations.
2. Comprehensive physical examination (complete medical examination) including those for school, sports, working papers, and new admissions.
3. Medically prescribed laboratory tests such as for anemia, sickle cell, and diabetes.
4. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications.
5. Mental health services including evaluation, diagnosis, treatment, and referrals.
6. For Adolescent Students: Reproductive health care services, including abstinence counseling, contraception [dispensing of birth control pills, condoms, Depo (the shot), LARC, other FDA approved methods] testing for pregnancy, STI screening and treatment, HIV testing, and referrals for abnormal results, as age appropriate and medically indicated.
7. Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and smoking abuse, as well as education on abstinence and prevention of pregnancy, sexually transmitted infections, and HIV, as age appropriate and medically indicated.
8. Dental examinations including: diagnosis, treatment, and sealants where available.
9. Referrals for service not provided at the school-based health center.
10. Annual health questionnaire/survey.

NEW YORK CITY DEPARTMENT OF EDUCATION'S — BOX 2
FACT SHEET FOR PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION
HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature on the reverse side of this form authorizes release of medical information as specified below. This information may be protected from disclosure by federal privacy law and state law.

By signing this consent, I am authorizing medical information as specified below to be given to the Board of Education of the City of New York (a/k/a New York City Department of Education), either because it is required by law or by Chancellor's regulation, or because it is necessary to protect the health and safety of the student. Upon my request, the facility or person disclosing this medical information must provide me with a copy of this form. Parents are required by law to provide certain information to the school, like proof of immunization. Failure to provide this information may result in the student being excluded from school.

My questions about this form have been answered. I understand that I do not have to allow release of my child's medical information, and that I can change my mind at any time and revoke my authorization by writing to the School-Based Health Center. However, after a disclosure has been made, it cannot be revoked retroactively to cover information released prior to the revocation.

I authorize the Family Health Centers at NYU Langone (HCSP) School-Based Health Center to release specific medical information of the student named on the reverse page to the Board of Education of the City of New York (a/k/a New York City Department of Education).

I consent to the release from the School-Based Health Center to the NYC Department of Education and from the NYC Department of Education to the School-Based Health Center, of medical information outlined below in order to meet regulatory requirements and ensure that the school has information needed to protect my child's health and safety. I understand that this information will remain confidential in accordance with Federal and State law and Chancellor's Regulations on confidentiality:

Information Required by Law or Chancellor's Regulation including but not limited to:

- Comprehensive Physical Exam (Form CH-205 or Equivalent such as sports exams, etc.)
- Vision and hearing screening results
- Immunizations (required/recommended)
- Tuberculin Test results

Information to Protect Health and Safety:

- Conditions which may require emergency medical treatment including chronic illness
- Conditions which limit a student's daily activity
- Diagnosis of certain communicable diseases (does NOT include HIV/STI information and other confidential services protected by law).
- Health insurance coverage
- Enrollment in School-Based Health Center
- Individualized Education Program (IEP)

Time Period During Which Release of Information is Authorized:

From: Date that form is signed on opposite page **To**: Date that student is no longer enrolled in the SBHC

NOTE: This School Based Health Center Parental Consent Form has been approved by DOE/OSH

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are Committed to Your Privacy
NYU Langone Health is committed to maintaining the privacy of your health information. We use a secure electronic health record to store your information. We will only use or disclose (share) your health information as described in this notice. You will be asked to sign an acknowledgment that you have received this Notice.

Who Follows This Notice
This is a joint Notice which is followed by all employees, medical staff, trainees, students, volunteers, and agents of NYU Langone Health at these locations:
- NYU Langone Hospitals (including the NYU Langone Home Health Care)
- NYU Grossman School of Medicine (including our Faculty Group Practices)
- The Family Health Centers at NYU Langone
- Southwest Brooklyn Dental Practice

NYU Langone Hospitals and the NYU Grossman School of Medicine participate in an Organized Health Care Arrangement with the Family Health Centers at NYU Langone, the Southwest Brooklyn Dental Practice, and may use and share between each other your information to carry out treatment, payment, and health care operations relating to this arrangement.
If NYU Langone Health professionals provide you with treatment or services at other locations, for example at the Manhattan VA Medical Center or Bellevue Hospital Center, the Notice of Privacy Practices you receive there will apply.

Using and Sharing Your Information
This section describes the different ways that we may use and share your information. We will usually contact you for these purposes by phone, but if you have given us your email address or permission to send a text message, we may contact you that way.
Communication by text message and email may be unsecure and unencrypted, and by providing us your mobile phone number or email, you authorize NYU Langone Health to communicate with you in this way.
We mainly use and share your information for treatment, payment, and health care operation purposes. This means we use and share your health information:
- with other health care providers who are treating you or with a pharmacy that is filling your prescription;
- with your insurance plan to collect payment for health care services or to get pre-approval for your treatment; and
- to run our business, improve your care, educate our professionals, and evaluate provider performance.

Sometimes we may share your information with our business associates, such as a billing service, who help us with our business operations. All of our business associates must protect the privacy and security of your health information just as we do.
We may also use or share your information to contact you:
- about health-related benefits or services.
- about your upcoming appointments.
- to see if you would like to take part in research projects.
- about fundraising for NYU Langone Health.

You have the right to opt out of fundraising communications. You can do this by contacting the NYU Langone Health Development Office at developmentoffice@nyulangone.org or by phone at 212-404-3640 or, toll free, 1-800-422-4483.
If you do not wish to be notified of research projects you may be able to participate in, you can contact research-contact-optout@nyulangone.org or 1-855-777-7858.
Special protections apply if we use or share sensitive health information. This includes HIV-related information, mental health information, alcohol or drug abuse treatment information, or genetic information. For example, under New York State Law, confidential HIV-related information can only be shared with persons allowed to have it by law, or persons you have allowed to have it by signing a specific authorization form. If your treatment involves this information, you may contact the Privacy Officer for further explanation.
We are also allowed, and sometimes required by law, to share your information in other ways. We have to meet many conditions in the law before we can share your information for the following reasons. Some examples of each include:
- Public health and safety: reporting diseases, births, or deaths; reporting suspected abuse, neglect, or domestic violence; to avoid a serious threat to health or public safety; monitoring product recalls; and reporting information for safety and quality purposes.
- Research: analyzing health record projects that have been approved by our institutional review board (IRB) and are of low risk to your privacy; preparing for a research study; studies that only involve decedents' information.
- Judicial and administrative proceedings: responding to a court or administrative order.
- Workers' compensation and other government requests: workers' compensation claims payment or hearings; health oversight agencies for activities authorized by law; special government functions (military, national security).
- Law enforcement: with a law enforcement official to identify or find a suspect or missing person.
- Comply with the law: to the Department of Health and Human Services to see if we are complying with federal privacy law.
- Disaster relief situation: sharing your location and general location for the purpose of notifying your family, friends, and agencies chartered by law to assist in emergency situations.
- To organizations that handle organ, tissue, or eye donation or transplantation.
- To a coroner, medical examiner, or funeral director as needed to do their jobs.
- Incidental to a permitted use or disclosure: calling your name in a waiting area for an appointment and others in the waiting area may hear your name called. We make reasonable efforts to limit these incidental uses and disclosures.

In the following situations, we may use or share your information, unless you object or if you specifically give us permission. If for some reasons you are not able to tell us your preferences, for example if you are unconscious, we may share your information if we believe it is in your best interest.
- For our patient directory, including to our chaplaincy services department, such as a priest or rabbi.
- With your family, friends, or others involved in your care or payment for your care.

In the following situations, we will only use or share your information if you give us permission:
- For marketing purposes
- Sale of your information or payments from a third party
- Most sharing of psychotherapy notes
- Any other reasons not described in this Notice

You can revoke (take back) that permission, except when we have already relied on it, by contacting the Privacy Officer.

Your Rights
When it comes to your health information, you have certain rights. You may:
▪ Request confidential communications. You can ask us to contact you in a certain way, for example, by cell phone. We will say "yes" to all reasonable requests.
▪ Ask us to limit what we use or share for your treatment, payment, and healthcare operations. We are not required to agree to your request, but we will review it. When you pay for services out-of-pocket, in full, and ask us not to share the information with your insurance plan, we will agree unless a law requires us to share that information.
▪ Ask us to correct your medical record if it is inaccurate or incomplete. We may say "no" to your request, but we will tell you why in writing within 60 days.
▪ Get a list of those with whom we have shared information. You can ask for a list (accounting) of the times we shared your information and why for the six years prior to your request. Not all disclosures will be included in this list, such as those made for treatment, payment, or health care operations. You have the right to get this list one time every 12 months without charge, but we may charge you for the cost of providing additional lists during that time.
▪ Get a copy of this privacy Notice. Just ask us and we will give you a copy in the format you would like (paper or electronic).
▪ Choose someone to act for you. This "personal representative" can exercise your rights and make choices about your health information. Generally, parents and guardians of minors will have this right for the child, unless the minor is permitted by law to act on their own behalf.
▪ File a complaint if you feel your rights have been violated. You may contact the NYU Langone Privacy Officer or the Secretary of the United States Department of Health and Human Services. We will not retaliate or take action against you for filing a complaint.
▪ Request additional privacy protections with respect to your electronic medical record.

Our Responsibilities
▪ We are required by law to maintain the privacy of your protected health information.
▪ We will notify you if a breach occurs that may have compromised the privacy or security of your identifiable information.
▪ We must follow the practices described in this Notice and give you a copy of it.
▪ We reserve the right to change the terms of this Notice and the changes will apply to all information we have about you. The new Notice will be available upon request and on our website at www.nyulangone.org

Questions or Concerns
If you have a question or wish to exercise your rights described in this Notice, please contact the Privacy Officer at:
One Park Avenue, 3rd Floor, New York, New York 10016, Attention: Privacy Officer, by phone to 1-877-PHI-LOSS or 212-404-4079, or via email to compliance.help@nyulangone.org
Most requests to exercise your rights must be made in writing to the Privacy Officer or the appropriate doctor's office or hospital department. For more information or to get a request form, contact the Privacy Officer or visit http://nyulangone.org/policies-disclaimers/hipaa-patient-privacy.

REQUEST FOR ACKNOWLEDGMENT

By signing this form, I acknowledge that I have received a copy of NYU Langone Health's Notice of Privacy Practices.

Patient Name

X **Signature of Parent/Guardian**

Date: _____

FAMILY HEALTH CENTERS AT NYU LANGONE

Guidelines for Adolescent Preventive Services
Parent/Guardian Questionnaire

Confidential (Your answers will not be given out.)

Date _____

Adolescent's name _____ Adolescent's birthday _____ Age _____

Parent/Guardian name _____ Relationship to adolescent _____

Your phone number: Home _____ Work _____

Adolescent Health History

1. Is your adolescent allergic to any medicines?
   ☐ Yes ☐ No If yes, what medicines? _____

2. Please provide the following information about medicines your adolescent is taking.

Name of medicine	Reason taken	How long taken

3. Has your adolescent ever been hospitalized overnight?
   ☐ Yes ☐ No If yes, give the age at time of hospitalization and describe the problem.

Age	Problem

4. Has your adolescent ever had any serious injuries?
   ☐ Yes ☐ No If yes, please explain. _____

5. Have there been any changes in your adolescent's health during the past 12 months?
   ☐ Yes ☐ No If yes, please explain. _____

6. Please check (✓) whether your adolescent ever had any of the following health problems:
   If yes, at what age did the problem start:

	Yes	No	Age		Yes	No	Age
ADHD/learning disability	☐	☐	_____	Headaches/migraines	☐	☐	_____
Allergies/hayfever	☐	☐	_____	Low iron in blood (anemia)	☐	☐	_____
Asthma	☐	☐	_____	Pneumonia	☐	☐	_____
Bladder or kidney infections	☐	☐	_____	Rheumatic fever or heart disease	☐	☐	_____
Blood disorders/sickle cell anemia	☐	☐	_____	Scoliosis (curved spine)	☐	☐	_____
Cancer	☐	☐	_____	Seizures/epilepsy	☐	☐	_____
Chicken pox	☐	☐	_____	Severe acne	☐	☐	_____
Depression	☐	☐	_____	Stomach problems	☐	☐	_____
Diabetes	☐	☐	_____	Tuberculosis (TB)/lung disease	☐	☐	_____
Eating disorder	☐	☐	_____	Mononucleosis (mono)	☐	☐	_____
Emotional disorder	☐	☐	_____	Other: _____	☐	☐	_____
Hepatitis (liver disease)	☐	☐	_____				

7. Does this office or clinic have an up-to-date record of your adolescent's immunizations (record of "shots")?
   ☐ Yes ☐ No ☐ Not sure

Family History

8. Some health problems are passed from one generation to the next. Have you or any of your adolescent's *blood* relatives (parents, grandparents, aunts, uncles, brothers or sisters), living or deceased, had any of the following problems? If the answer is "Yes," please state the age of the person when the problem occurred and his or her relationship to your adolescent.

	Yes	No	Unsure	Age at Onset	Relationship
Allergies/asthma	☐	☐	☐	_____	_____
Arthritis	☐	☐	☐	_____	_____
Birth defects	☐	☐	☐	_____	_____
Blood disorders/sickle cell anemia	☐	☐	☐	_____	_____

AA59:97-894:11/97

	Yes	No	Unsure	Age at Onset	Relationship
Cancer (type_____)	☐	☐	☐	_____	_____
Depression	☐	☐	☐	_____	_____
Diabetes	☐	☐	☐	_____	_____
Drinking problem/alcoholism	☐	☐	☐	_____	_____
Drug addiction	☐	☐	☐	_____	_____
Endocrine/gland disease	☐	☐	☐	_____	_____
Heart attack or stroke *before* age 55	☐	☐	☐	_____	_____
Heart attack or stroke *after* age 55	☐	☐	☐	_____	_____
High blood pressure	☐	☐	☐	_____	_____
High cholesterol	☐	☐	☐	_____	_____
Kidney disease	☐	☐	☐	_____	_____
Learning disability	☐	☐	☐	_____	_____
Liver disease	☐	☐	☐	_____	_____
Mental health	☐	☐	☐	_____	_____
Mental retardation	☐	☐	☐	_____	_____
Migraine headaches	☐	☐	☐	_____	_____
Obesity	☐	☐	☐	_____	_____
Seiures/epilepsy	☐	☐	☐	_____	_____
Smoking	☐	☐	☐	_____	_____
Tuberculosis/lung disease	☐	☐	☐	_____	_____

9. With whom does the adolescent live most of the time? *(Check all that apply.)*

☐ Both parents in same household
☐ Mother
☐ Father
☐ Other adult relative
☐ Stepmother
☐ Stepfather
☐ Guardian
☐ Brother(s)/ages _____
☐ Sister(s)/ages _____
☐ Other _____
☐ Alone

10. In the past year, have there been any changes in your family? *(Check all that apply.)*

☐ Marriage
☐ Separation
☐ Divorce
☐ Loss of job
☐ Move to a new neighborhood
☐ A new school or college
☐ Births
☐ Serious illness
☐ Deaths
☐ Other _____

Parental/Guardian Concerns

11. Please review the topics listed below. Check (✓) if you have a concern about your adolescent.

	Concern About My Adolescent		Concern About My Adolescent
Physical problems	☐	Guns/weapons	☐
Physical development	☐	School grades/absences/dropout	☐
Weight	☐	Smoking cigarettes/chewing tobacco	☐
Change of appetite	☐	Drug use	☐
Sleep patterns	☐	Alcohol use	☐
Diet/nutrition	☐	Dating/parties	☐
Amount of physical activity	☐	Sexual behavior	☐
Emotional development	☐	Unprotected sex	☐
Relationships with parents and family	☐	HIV/AIDS	☐
Choice of friends	☐	Sexual transmitted diseases (STDs)	☐
Self image or self worth	☐	Pregnancy	☐
Excessive moodiness or rebellion	☐	Sexual identity (heterosexual/homosexual/bisexual)	☐
Depression	☐	Work or job	☐
Lying, stealing, or vandalism	☐	Other: _____	☐
Violence/gangs	☐		

12. What seems to be the greatest challenge for your teen? _____

13. What is it about your teen that makes you proud of him or her? _____

14. Is there something on your mind that you would like to talk about today?

What is it? _____

15. Can we share your answers to Question 13 with your teen? ☐ Yes ☐ No

FAMILY HEALTH CENTERS AT NYU LANGONE

Family Health Centers at NYU Langone

Child (0-11 Years Old) MyChart at NYU Langone Proxy Access Request and Authorization Form

Requirements and Procedures

- Parent or individual requesting access must have parental or legal guardianship rights.
- Parent/Guardian Authorization Form must be complete and signed.
- The proxy will have access to all features of MyChart at NYU Langone on behalf of the patient.
- The proxy must have his/her own MyChart at NYU Langone account because the patient's chart will be accessed through the proxy's MyChart at NYU Langone record.

I understand that:

- MyChart at NYU Langone is intended as a secure online source of confidential medical information.
- **MyChart at NYU Langone is not to be used in an emergency.**
- Use of MyChart at NYU Langone is voluntary and I am not required to authorize proxy access.
- I must select a confidential password to maintain my password securely and change my password if I believe it may have been compromised in any way.
- If I share my MyChart at NYU Langone ID and password with another person, that person may be able to view my or my child's health information, as well as information about any adult who has authorized me as a MyChart at NYU Langone proxy.
- If I have proxy access, I must log in to my own MyChart at NYU Langone account and click on "View Other Records" to access another patient's record.
- MyChart at NYU Langone contains selected, limited medical information from a patient's medical record and is not the complete medical record.
- My activities within MyChart at NYU Langone may be tracked by computer audit and entries I make may become part of the medical record.
- Access to MyChart at NYU Langone is provided by NYU Langone Medical Center as a convenience to its patients and that NYU Langone Medical Center has the right to deactivate access at any time for any reason. A child's access to online medical information is terminated when all parent/legal guardian access is terminated.
- Parent/Legal Guardian access to a child's record is terminated when:
    - Child or parent/legal guardian submits a request or revokes online
    - Child turns 12 years old
    - Child advises and provides evidence to NYU Langone Medical Center of his/her emancipated status
    - Parent/parent or parent/child access disputes cannot be resolved
- Communications on behalf of your child must be sent through MyChart at NYU Langone from your child's record. Responses will be received in your child's record. MyChart at NYU Langone email alerts will be sent to the email address entered in the child's record.

Completing this form will establish a MyChart at NYU Langone record for the patient and proxy. Return completed forms to your provider's office or to_____.

If you already have a MyChart at NYU Langone account, you will receive a MyChart at NYU Langone message when access to the additional patient's record is available, typically 5 to 7 business days after completed request and authorization form is received.

PATIENT TO BE ENABLED FOR PROXY ACCESS:

Name: _____ Date of Birth: _____ Email: _____

Address/Phone #: _____/_____

PROXY (PARENT/LEGAL GUARDIAN): I am requesting access to the medical information available on MyChart at NYU Langone for the patient named above and agree to abide by the above terms and conditions of MyChart at NYU Langone and all other terms and condition viewable online within MyChart at NYU Langone.

Name: _____ Date of Birth: _____ Email: _____

Address/Phone #: _____/_____

_____/_____/_____

Proxy Signature Relationship to Patient Date