Vanderbilt University Medical Center

Parental Access to the My Health at Vanderbilt (MHAV) Account of a Teen 13-17 Years Old

MHAV Access - Child 13-17

Patient Label or Patient Identifiers

Patient Name: ______________________________________

Patient Date of Birth: ______/______/______ Last 4 digits of the Patient's Social Security Number: ____________

Parent's/Legal Representative's Agreement

Email Address of Parent/Legal Representative: ____

You must provide an email address. Notice of MHAV messages in your account will be sent only to this email address. **Previous email addresses will be deleted.**

Parent's/Legal Representative's Name: ____

Address: ____

Parent's/Legal Representative's Date of Birth: ____________________ Phone Number: ____________________

Last 4 digits of Parent's/Legal Representative's Social Security#: ____________

Are you currently or have you ever been a patient at Vanderbilt? ☐ Yes ☐ No

Former Name(s), such as maiden name: ____

Relation to child: ☐ Parent ☐ Legal Representative

Primary access to a teen's account is only available to parents or individuals with documented status as a legal representative.

I am the parent or legal representative of the teen named above and I request access to the teen's information online through MHAV. I understand the requirements and procedures for accessing the teen's information online through MHAV. I understand the teen will also have access to their own MHAV account. I understand if the teen revokes their MHAV account, then my access will also be revoked. All the information I have provided is correct, and I have rights to access the teen's information online through MHAV.

Parent's/Legal Representative's Print Name: ____

Parent's/Legal Representative's Signature: ____

Relation: ____ **Date:** ____________ **Time:** ________

This form can also be used to grant access for a parent or legal representative of a teen who has a medical condition determined by the teen's provider that prevents the teen from participating in making MHAV access decisions. The provider signs below to signify such a condition exists for this patient.

Provider Print Name: ____ Title: ____________________

Provider Signature: ____ Date: __________ Time: ________

FOR CLINIC USE ONLY:

Parent's/Legal Representative's ID verified by VUMC Staff or Provider:

Print Name: ____ Title: ____________________

Signature: ____ Date: __________ Time: ________

Fax to (615) 875-2820.
Or, if you have access to campus mail, send to HealthIT, My Health at Vanderbilt, 3401 West End Suite 500 E, Nashville, TN 37203 Campus Zip 8363

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Patient Identifiers

Patient Name: ___________________________________

Patient Date of Birth: ______/______/______

Last 4 digits of the Patient's Social Security Number: ________________

Parent/Legal Representative: __________________________________

Teen's Agreement

Email Address of Teen: ____

You must provide an email address. Notice of MHAV messages in your account will be sent only to this email address.

I request access to My Health at Vanderbilt (MHAV). I agree to allow the parent or legal representative named on Page 1 of this form to access my medical information in my MHAV account. I understand that I may revoke this access any time by asking my doctor to do so.

As the patient and a minor 13-17 years old (teen), I understand that:

- I will receive an email with information on how to open my MHAV account;
- I must log in to www.myhealthatvanderbilt.com with my own user ID and password;
- To protect the privacy of my health information, I will not share my user 1D or password with anyone;
- I agree to abide by the terms and conditions on the MHAV site;
- When I turn 18 years old, access by my parent or legal representative will end;
- MHAV email alerts will be sent to the email address I have given above;
- If I have a MHAV account, I must allow at least one parent or legal representative to have access to my MHAV account. This means my parent or legal representative will see all information in my MHAV account; and
- I must not use MHAV in an emergency. In case of medical emergency, I should call 911.

Patient Print Name: ____

Patient Signature: ____ **Date:** ___________ **Time:** _________

Return this completed form and any required documentation to your Vanderbilt Provider.

FOR CLINIC USE ONLY:

Parent's/Legal Representative's ID verified by VUMC Staff or Provider:

Print Name: ____ Title: ____________________

Signature: ____ Date: __________ Time: _________

Fax to (615) 875-2820.
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