Vanderbilt University Medical Center

Parental/Legal Representative 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

Teen/Patient Name: _____

Teen/Patient Date of Birth: _____/_____/_____

Last 4 digits of the Teen/Patient's Social Security Number: _____

Parent's or Legal Representative's Agreement

Parent's/Legal Representative's Email: _____

*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: _____

City: _____ State: _____ Zip Code: _____

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, or other names: _____

Relation to child: ☐ Parent ☐ Stepparent ☐ Other Legal Representative: _____

**For representatives other than parents, please provide legal documentation to the clinic or fax to 615-875-2820. This includes Custody, Power of Attorney, Conservatorship, Guardianship, Department of Children Services Letter for Foster Parents, etc. You may also submit documentation via secure email to MHAVLegal@vumc.org. Please note that email that is not sent securely (i.e., unencrypted email) may be intercepted and seen by others during transmission. By choosing to send information by unencrypted email, you accept these risks.*

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:** _____

Vanderbilt University Medical Center

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

MHAV Access - Child 13-17

Patient Identifiers

Teen/Patient Name: _____

Patient Date of Birth: _____/_____/_____

Last 4 digits of the Teen's/Patient's Social Security Number: _____

Parent's/Legal Representative's Name: _____

Teen's Agreement

Teen's Email: _____

Teen's Mobile Phone Number: _____

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 provider or by calling the Help Desk at 615-343-HELP (4357) 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 ID 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 a medical emergency, I should call 911.

Patient Print Name: _____

Patient Signature: _____ **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: _____

Before you leave, return this completed form and any required documentation to a Vanderbilt staff member.

FOR CLINIC USE ONLY:

Parent's/Legal Representative's Government-Issued Photo ID verified by VUMC Staff or Provider:

Print Full Name: _____ Title: _____

Full Signature: _____ Date: _____ Time: _____

Vanderbilt staff, please fax to (615) 875-2820.