



PT NAME

MR #

This form is used to: Access to Your Child's One Chart | PATIENT account online (Legal Parent)

To request access to your child's One Chart | PATIENT record, please complete this Child Proxy Form and return it to the address below. Please allow 14 business days for processing after receipt of your complete application. Please note, your child's chart will be accessed through your One Chart | Patient portal log-in.

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

PROXY

Name (last, first, middle initial) _____
 Date of Birth: _____ Last 4 digits of SSN: _____
 Street Address: _____ City: _____ State: _____ Zip: _____
 Email Address: _____ Phone Number: _____

Once your child reaches **age 19**, he/she is no longer a minor under Nebraska law and you will no longer have access to his/her One Chart | PATIENT record. Your child may apply for his/her own log-in at age 19.

Please provide the following information for each child. All fields are required.

- A. Name (last, first, middle initial) _____
 Date of Birth: _____ Primary Clinic: _____
- B. Name (last, first, middle initial) _____
 Date of Birth: _____ Primary Clinic: _____
- C. Name (last, first, middle initial) _____
 Date of Birth: _____ Primary Clinic: _____
- D. Name (last, first, middle initial) _____
 Date of Birth: _____ Primary Clinic: _____

ONE CHART Attestation

- By signing below, I am certifying to the fact that I am the legal parent of the child(ren) listed above and have all right and authority to view his/her/their medical information.
- I acknowledge that it is my responsibility to keep my One Chart | PATIENT log-in information confidential or risk others having access to the confidential information contained therein.
- I understand that One Chart | PATIENT contains selected, limited medical information from a patient's medical record and that One Chart | PATIENT does not reflect the complete contents of the medical record. I also understand that a paper copy of a patient's medical record may be requested from my provider.
- I understand that my activities within One Chart | PATIENT may be tracked and that entries I make may become part of the medical record.
- I further agree to abide by the Terms and Conditions of use of One Chart | PATIENT which I have the responsibility to review.

Signature of Parent (Required) _____ Relationship to Patient _____ Date _____

Return Form to: 10304 Crown Point Avenue, Omaha, NE 68134-9100

PROXY SET UP COMPLETED BY _____ CLINIC STAFF? YES _____ NO _____ Please send completed form to Zip 9100
 Clinic Name

Proxy completed by: _____ Date _____
 Print Full Name