Young Adults 14 - 17 years
Teen Connection Request

Please allow 10 business days for processing

Send Completed Form to one of the following or hand in at patient's clinic

Fax: 866-846-7864

Postal: UnityPoint Health
Attn. MyUnityPoint Registration
3851 River Ridge Drive NE
Cedar Rapids IA 52402

Contact Technical Support: 877-224-4430

Patient Information

Patient's Name: _____ Patient's Date of Birth: _____
First MI Last

Patient's Home Address:

_____
Street Address City State Zip Code

Patient's Clinic: _____ Patient's Primary Care Provider: _____

Patient's E-mail: _____ Patient's Phone: _____

**Minor children between 14 – 17 years of age may establish their own My Chart account, via MyUnityPoint, if they obtain parental or legal guardian authorization. The parent or guardian must complete and sign this form for access to be granted. **

Parent/Guardian Information

Parent/Guardian Name: _____ Date of Birth: _____
First MI Last

Parent/Guardian Home Address:

_____
Street Address City State Zip Code

E-mail: _____ Phone: _____

Identify your relationship to the Patient:

- ☐ Mother
- ☐ Father
- ☐ Legal Guardian
- ☐ Other Authorized Healthcare Representative (if this box is selected, please provide specific information and include any supporting documentation with this form): _____

MyUnityPoint

Young Adults 14 - 17 years
Teen Connection Request

Please allow 10 business days for processing

Send Completed Form to one of the following or hand in at patient's clinic

Fax: 866-846-7864

Postal: UnityPoint Health

Attn. MyUnityPoint Registration

3851 River Ridge Drive NE

Cedar Rapids IA 52402

Contact Technical Support: 877-224-4430

Authorization to Release Protected Health Information

My signature below represents that I authorize UnityPoint Health to create a My Chart account for my minor child and I authorize the release of medical information via MyUnityPoint to my minor child, the patient named above ("Authorized Child"). **I understand that UnityPoint Health includes all UnityPoint Health hospitals, clinics and home care services offered by UnityPoint Health.** I understand that this authorizes my child to access health information, including but not limited to treatment, evaluations, consultations, lab tests, or procedures performed by UnityPoint Health providers or other affiliated providers. I acknowledge that health information provided via MyUnityPoint may contain sensitive health information, including adoption or birth records and genetic testing results, and it may be appropriate to discuss these topics with my child prior to authorizing this access. I acknowledge that my child may be entitled by state law to privacy in relation to care for his or her mental health, substance abuse, and for STI or pregnancy testing.

If I am submitting this form with an electronic signature, I understand that submission of my electronic signature via Adobe EchoSign® is a valid signature that meets the requirements for a signature under federal and state law.

Parent/Guardian Printed Name Parent Signature Date

As the Authorized Child, I acknowledge that it is my responsibility to safeguard my login information for MyUnityPoint and I understand that sharing such information with anyone will allow them to access my personal health information contained in MyUnityPoint.

If I am submitting this form with an electronic signature, I understand that submission of my electronic signature via Adobe EchoSign® is a valid signature that meets the requirements for a signature under federal and state law.

Authorized Child Printed Name Child Signature Date

Clinic Reviewer Printed Name Clinic Signature Name of Clinic

Approve ☐ Denied ☐ Reason: _____