If label not available, please fill in below.

NAME: ______________________

DOB: ______________________

MRN: ______________________

MYWELLSPAN TEEN ACCESS AGREEMENT FORM

This form must be completed in the presence of a WellSpan Health staff member who will serve as the witness. Only minors between the ages of 13 and 17 may access their MyWellSpan account.

I, ______________________ (print parent name), the parent or guardian of ______________________ (print minor's name)

("minor") give permission for the minor to have access to his/her MyWellSpan account. This permission does not remove any existing proxy relationship that may be linked to the minor's account and will not give the minor the ability to invite others to have access to his or her health information.

I understand that if I wish to rescind my child's access to his or her MyWellSpan account I can contact the MyWellSpan Customer Support Line at 1-866-638-1842.

______________________	______________________	__________	__________
Parent/Guardian Signature	Printed Name	Date	Time
Minor's Signature	Printed Name	Date	Time
Witness Signature	Printed Name	Date	Time

Form #11922 Rev. (12/19)
Administrative