

## MyHSA Child Proxy Application

Thank you for applying for MyHSA Patient Portal **Proxy**, which is available only to persons with their own MyHSA Patient Portal account. **Parents and legal guardians of a minor child between the ages of 0-15 years can make applications for Patient Portal Proxy**, providing that you are not legally prohibited by a court of law from doing so.

### Minor Patients

You must be the child's parent or legal guardian to access the record. Once a child turns 16, access is automatically revoked from the parent/guardian. Due to HSA's Policy, there are limitations, based on a patient's age, restricting what you can view in your child's/ward's MyHSA Patient Portal:

- Age 0 - less than 16: You have full access to their account
- Age 16-17: No online access to their patient portal account. Requests must be made in person, parent and child, to the Medical Records department. 16 & 17 year olds may register for the Patient Portal on their own behalf
- Age 18 or older: No online access to their patient portal account

These age range limitations do not affect any legal rights you have to access your child/ward's medical records by other means. To request a copy of your child/ward's records, please contact the Health Information Medical Records Department - Release of Information Desk to make your application.

In order to complete your **Proxy** application, please provide us with the following certified documents:

- a. Original or Certified Birth Certificate **or**
- b. Original or Certified Adoption Certificate or Court Appointed Legal Guardianship Certificate of Child showing Parents name on same **and**
- c. Government issued **Photo** ID of Parent or ward of minor child

By signing below, I acknowledge and agree that:

- I will be using my own MyHSA Patient Portal account at the HSA to access the Child's account.
- I will comply with the terms and conditions on the MyHSA Patient Portal.
- I will keep my password confidential and not share this information with anyone.
- I must have parental rights or legal guardianship rights to access this Child's record.
- I have not been denied periods of physical placement with the Child and there are no court orders or restraining orders in effect limiting my access to this Child's medical records and/or information.
- Communications on behalf of the Child through MyHSA must be sent from the Child's record and responses will be received in the Child's record.

- MyHSA e-mail alerts will be sent to the e-mail address entered under Parent/Legal Guardian ("Proxy") Information.
- The age range limitations do not affect any legal right I have to access the Child's record by other means. I can request a paper copy of the Child's record, by contacting the Health Information Medical Records Department.
- On the Child's 16th birthday, I will **no longer** have access to the Child's MyHSA Proxy account.
- At the age of 16, the patient (child) can apply for their own MyHSA account.

## **Health Information Medical Records**

### **Hours of Operation:**

Monday - Friday 8:00am - 4:30pm

**Phone:** 345-244-2780 / 2779 / 2783

**Email:** roirequest@hsa.ky

**CAYMAN ISLANDS HEALTH SERVICES AUTHORITY  
95 HOSPITAL ROAD  
P.O. BOX 915  
GRAND CAYMAN, KY1-1103  
CAYMAN ISLANDS  
345-949-8600  
info@hsa.ky**



**MyHSA Child Proxy  
Application Form**



**PRINT all information clearly and in BLOCK letters**

**Patient (Child's) Name:**

First: \_\_\_\_\_ Middle \_\_\_\_\_ Surname \_\_\_\_\_

**Relationship to the child**     Parent     Legal Guardian

**Parent/Guardian Name (of minor child):**

First: \_\_\_\_\_ Middle \_\_\_\_\_ Surname \_\_\_\_\_

**Patient (Child's) Date of Birth:** \_\_\_\_\_

**Parent/Guardian Phone:** (W) \_\_\_\_\_ (C) \_\_\_\_\_

**Parent/Guardian Email Address:** \_\_\_\_\_

(PLEASE PRINT)

**Signature of Applicant/Requester:** \_\_\_\_\_ **Print Name:** \_\_\_\_\_

**ID #** \_\_\_\_\_ **Type** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FOR HEALTH INFORMATION MEDICAL RECORDS (HIM) OFFICIAL USE ONLY**

**Application Received and Processed By:**

User ID: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Supporting Documentation verified:**

- Birth Certificate
- Adoption Certificate/Court Appointed Legal Guardianship Certificate of Child
- ID # \_\_\_\_\_ Type \_\_\_\_\_

**Account Status**

- Approved
- Denied
  - Insufficient Documentation
  - ID not verified
  - Legal Document on file contradicting application

**Date Applicant notified of Denial:** \_\_\_\_\_ **Denial Notice sent by:** \_\_\_\_\_

**Date Application Resubmitted:** \_\_\_\_\_

**Processed by: User ID** \_\_\_\_\_ **Print name:** \_\_\_\_\_

Account Approved  Denied: \_\_\_\_\_

**Date Approved package sent to IS Call Center:** \_\_\_\_\_ **By:** \_\_\_\_\_

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**FOR OFFICIAL USE ONLY**

**Call Center:**

**Date Application Received:** \_\_\_\_\_ **By:** \_\_\_\_\_

- Account Created by: \_\_\_\_\_
- Date Patient Notified \_\_\_\_\_