



**MYWELLSPAN TEEN ACCESS
AGREEMENT FORM**

If label not available, please fill in below.	
NAME:	_____
DOB:	_____
MRN:	_____

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, _____, the parent or guardian of _____
(print parent name) (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

