Stormont Vail Health Cotton O'Neil

Please Mail Form to:
Stormont Vail Health
MyChart Access
Clinic Release of Information Department
1500 S.W. 10th Ave., Topeka, KS 66606
MedicalRecordRequest@stormontvail.org

Request for MyChart Access for Minors Aged 14-17
Diminished Capacity

As the parent or guardian of (Name) _____, (Date of Birth) _____, a minor between the ages of 14 -17, I hereby request access to their medical record via MyChart, as the minor does not possess the maturity and mental capacity to provide the necessary consent, in lieu of the consent/authorization customarily provided by their parent or guardian, in order to request and receive certain health care services as permitted under Kansas law.

_____
Signature of Parent or Guardian

_____
Printed Name of Parent or Guardian

_____
Date Signed

As the treating physician of the above-identified minor, I concur with the assessment that the minor does not possess the maturity or mental capacity to provide the necessary consent to obtain and receive health care services as permitted under Kansas law.

_____
Signature of Provider

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_____
Print Providers Name

_____
Date Signed