Name: ______________________________
DOB: _________________________
ID: ___________________________

MYKEYSTONE TEEN ACCESS AGREEMENT FORM

This form must be completed in the presence of a Keystone Health staff member who will serve as the witness. Only minors between the ages of 14 and 17 may access their MyKeystone account.

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

date of birth_____________________________(“minor) give permission for the minor to have access to his/her MyKeystone account. This permission does not remove any existing proxy relationship that may be linked to the minor's account and will not five 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 MyKeystone account, I can contact the MyKeystone Support Line at 717-217-1975.

____ ____________________________ ___________ __________
Parent/Guardian Signature Printed Name Date Time

____ ____________________________ ___________ __________
Minor's Signature Printed Name Date Time

____ ____________________________ ___________ __________
Witness Signature Printed Name Date Time