

**myViaChristi<sup>1</sup>**  
**Patient Portal Access Request Form**

**PATIENT IDENTIFICATION INFORMATION**

Name<sup>2</sup> (First, Middle, Last): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_ If under 18<sup>3</sup>, name of parent/legal guardian: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Patient Email Address (required): \_\_\_\_\_

Shared<sup>4</sup> email account:  Yes  No

**PROXY INFORMATION**

Proxy<sup>5</sup> Name(s) and email addresses, if any:

Name \_\_\_\_\_ Email \_\_\_\_\_

Name \_\_\_\_\_ Email \_\_\_\_\_

Proxy Relationship to Patient:

Parent  Legal Guardian/DPOA<sup>6</sup>  Shared email account  Other (specify) \_\_\_\_\_  
 Legal Documents provided

**SIGNATURE(S) and ACKNOWLEDGEMENT**

**By signing as the patient below and submitting this Enrollment Form, I acknowledge I will be sent an Invitation to register my User ID and Password for access to selected health information through myViaChristi. I further understand a link to the Consent and User Agreement of myViaChristi, including detailed information regarding access to and use of my health information, is on the myViaChristi website and I understand I must agree and accept the terms and conditions of the Consent and User Agreement for my account to be activated. I ACKNOWLEDGE THAT LOGGING ONTO THE PATIENT PORTAL THROUGH A MYVIACHRISTI ACCOUNT WILL CONSTITUTE MY AGREEMENT TO THE TERMS AND CONDITIONS OF THE CONSENT AND USER AGREEMENT.**

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Legal Guardian/Proxy (If required) \_\_\_\_\_ Date: \_\_\_\_\_

1 A link to the Consent and User Agreement regarding myViaChristi is on the myViaChristi website. The Consent and User Agreement provides detailed information regarding the myViaChristi patient portal. For a patient's myViaChristi account to be activated the patient must agree to the terms and conditions of the Consent and User Agreement on the website. A patient may terminate the Patient's myViaChristi account at any time. A patient may remove a Proxy from a myViaChristi account at any time (with the exception of minors 14 up to 18 years of age whose account must include a parent/legal guardian as a Proxy). To terminate or remove a Proxy from a myViaChristi account, contact Cerner at (877) 621-8014.

2 A minor patient 14 up to 18 years of age **is required** to list a parent/legal guardian in the Proxy section of this Enrollment Form and to obtain the signature of the listed parent/legal guardian on the Enrollment Form to establish a myViaChristi account. A parent/legal guardian of a minor patient 14 up to 18 years of age **is required** to sign this Enrollment Form for said minor to register a myViaChristi account. The refusal of either the minor patient or the parent/legal guardian to sign this Enrollment Form will result in denial of activation of said minor patient's myViaChristi account to both the minor patient and the parent/legal guardian.

3 A minor patient 14 up to 18 years of age **is required** to list a parent/legal guardian in the Proxy section of this Enrollment Form and to obtain the signature of the listed parent/legal guardian on the Enrollment Form to establish a myViaChristi account. A parent/legal guardian of a minor patient 14 up to 18 years of age **is required** to sign this Enrollment Form for said minor to register a myViaChristi account. The refusal of either the minor patient or the parent/legal guardian to sign this Enrollment Form will result in denial of activation of said minor patient's myViaChristi account to both the minor patient and the parent/legal guardian.

4 A patient with a *shared email address* (i.e. [thejonesfamily@sharedaccess.com](mailto:thejonesfamily@sharedaccess.com)) must list all individuals on the shared email account in the Proxy section of this Enrollment Form. myViaChristi is unable to establish multiple myViaChristi accounts for Patients sharing a single email address *except* where all others sharing the email account are listed under the Proxy section of the Enrollment Form.

5 Parent/legal guardian/Durable Power of Attorney (DPOA) other authorized representative.

6 This request must be accompanied by a copy of legal paperwork verifying the individual's Proxy status.

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VC4235 5/14

**PATIENT IDENTIFICATION**

