MyMidMichigan Proxy Access:
Minors Ages 0-10 or Adults with Diminished Capacity: Part 2

MidMichigan Health

Patient Information

Last Name: _____

First Name: _____

Date of Birth: _____

Parent or Legal Guardian Information

Last Name: _____

First Name: _____

Date of Birth: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Phone Number: _____

Relationship to Patient: _____

Email Address: _____

I am requesting proxy access to the patient's MyMidMichigan account. I certify that I am the patient's parent, legal guardian or personal representative, and have provided any necessary supporting documentation. I understand that without proper documentation, access will not be granted.

_____ _____

Parent or Legal Guardian Signature Date/Time