

# Parent of child(ren) 11 years and younger:

The FollowMyHealth patient portal at Chapel Hill Children's Clinic is designed to enhance secure patient and provider communications and is provided as a courtesy to our valued patients. Please complete and submit this form to the front desk to receive a portal invitation through email.

	<b>ACCOUNT ACCESS:</b>
Purpose for Access:	<input type="checkbox"/> I am 12-17 years of age and request access to my own medical record information
	<input type="checkbox"/> I am 12-17 years of age and grant Full Access to my medical records to the authorized user below
	<input type="checkbox"/> I am 18 years or older and request access to my own medical records
	<input type="checkbox"/> I am the parent of a child 11 years or younger and request Full Access to their medical records (proxy access will be terminated when your child reaches the age of 12 years and a new form will need to be signed by them to reconnect them to your proxy account)
	<input type="checkbox"/> I am REVOKING proxy access to my account from the authorized user below
	<input type="checkbox"/> I am REVOKING my own proxy access for the patient below

## Patient Information (Please print):

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
FIRST NAME MIDDLE NAME LAST NAME

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
FIRST NAME MIDDLE NAME LAST NAME

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
FIRST NAME MIDDLE NAME LAST NAME

Email address where invite/portal messages will be sent (if patient requesting their own access):

\_\_\_\_\_

I hereby authorize Chapel Hill Children's Clinic to disclose individually identifiable health information to the FollowMyHealth patient portal for my own, or proxy online access to health care information:

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

## Authorized User Information (please print): (Person receiving proxy access to a patient portal account)

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
FIRST NAME MIDDLE NAME LAST NAME

Email address where proxy invite/portal messages will be sent:

\_\_\_\_\_

Address: \_\_\_\_\_  
STREET ADDRESS CITY, STATE ZIP CODE

Phone Number: \_\_\_\_\_

Authorized User Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Parent of child(ren) 12 years and older:

The FollowMyHealth patient portal at Chapel Hill Children’s Clinic is designed to enhance secure patient and provider communications and is provided as a courtesy to our valued patients. Please complete and submit this form to the front desk to receive a portal invitation through email.

Purpose for Access:	<b>ACCOUNT ACCESS:</b>
	<input type="checkbox"/> I am 12-17 years of age and request access to my own medical record information
	<input type="checkbox"/> I am 12-17 years of age and grant Full Access to my medical records to the authorized user below
	<input type="checkbox"/> I am 18 years or older and request access to my own medical records
	<input type="checkbox"/> I am the parent of a child 11 years or younger and request Full Access to their medical records (proxy access will be terminated when your child reaches the age of 12 years and a new form will need to be signed by them to reconnect them to your proxy account)
	<input type="checkbox"/> I am REVOKING proxy access to my account from the authorized user below
	<input type="checkbox"/> I am REVOKING my own proxy access for the patient below

### Patient Information (Please print):

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
FIRST NAME MIDDLE NAME LAST NAME

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
FIRST NAME MIDDLE NAME LAST NAME

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
FIRST NAME MIDDLE NAME LAST NAME

Email address where invite/portal messages will be sent (if patient requesting their own access):

\_\_\_\_\_

I hereby authorize Chapel Hill Children’s Clinic to disclose individually identifiable health information to the FollowMyHealth patient portal for my own, or proxy online access to health care information:

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

### Authorized User Information (please print): (Person receiving proxy access to a patient portal account)

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
FIRST NAME MIDDLE NAME LAST NAME

Email address where proxy invite/portal messages will be sent:

\_\_\_\_\_

Address: \_\_\_\_\_  
STREET ADDRESS CITY, STATE ZIP CODE

Phone Number: \_\_\_\_\_

Authorized User Signature: \_\_\_\_\_ Date: \_\_\_\_\_