FollowMyHealth Individual Health Record Patient Portal
Minor (14-17) Patient Proxy Authorization

A Proxy Authorization means that you grant another person full access to your records as if they were you. This might be a parent, guardian or someone who helps you manage your health. To process your request all sections must be completed. **Please print clearly**.	*For Office use only* *Affix Patient Label Here* *or* Enter Medical Record #________________________________

Patient Name: *last:* ________________________ *first:* __________________ *middle initial:* ____
Street Address: ___________________________ **City**: ______________ **State**: ___ **Zip**:________
Date of Birth:____________ **Age**: ___ **Email Address:** __________________________________
Preferred Phone #: ______________________________

Proxy Information- Each proxy request requires a separate authorization be completed:
Proxy Name: *last:* ________________________ *first:* __________________ *middle initial:* ____
Date of Birth:_____________ **Last Four Digits SSN**: _________
Preferred Phone #: ______________________________
Street Address: ___________________________ **City**: ______________ **State**: ___ **Zip**:________
Legal Relationship to the Patient: ____

I allow FollowMyHealth to release my personal health information from my Jackson Clinic patient medical record to the Proxy listed above via an online FollowMyHealth account patient portal. I understand that:.

- For minors 14-17 years who sign this form, full proxy access will be granted and the authorization is valid for one year or up until the minor's 18th birthday (whichever is sooner). To renew access, a new authorization will need to be completed annually until the minor's 18th birthday.
- If I change my mind and no longer want to grant FollowMyHealth proxy access, I may let The Jackson Clinic know in writing at any time. This change will become effective no later than three (3) business day after the date that The Jackson Clinic receives my request to cancel proxy access. Any such change will not apply to information that has already been released before the effective date of the change.
- The Jackson Clinic cannot be responsible for the confidentiality of information that is released to/used by my Proxy. The Jackson Clinic cannot prevent my proxy from releasing the information to another person or organization. Once released to the Proxy, individual health information is no longer protected by federal and state privacy regulations.
- If I do not sign this form I will still be treated and payment, enrollment and eligibility for benefits will not be impacted.
- To be valid, this form must be completely filled out, signed, and dated. A photocopy, fax or electronically scanned and transmitted image is the same as the original.
- This form will be placed into my Jackson Clinic record. I can receive a signed copy of this form upon my request.
- For the Proxy to gain access to your FollowMyHealth account via the patient portal, the Proxy must activate the account with the code he/she will be given. The Proxy also must confirm that he/she has read and agrees to the terms and conditions of the FollowMyHealth Release of Information.

____ ______ /______ /______
Signature of Minor age 14-17 granting to the Proxy full access to FollowMyHealth — Today's Date

____ ______ /______ /______
Signature of Proxy — Today's Date