

## FollowMyHealth Individual Health Record Patient Portal Minor (Under Age 14) Patient Proxy Authorization

<p>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.</p> <p>To process your request all sections must be completed. <b>Please print clearly.</b></p>	<p><i>For Office use only</i></p> <p><i>Affix Patient Label Here</i> <i>or</i></p> <p>Enter Medical Record # _____</p>
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**Patient Name:** *last:* \_\_\_\_\_ *first:* \_\_\_\_\_ *middle initial:* \_\_\_\_\_  
**Street Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_ **Zip:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_ **Email Address:** \_\_\_\_\_  
**Preferred Phone #:** \_\_\_\_\_

<p><b>Proxy Information- Each proxy request requires a separate authorization be completed:</b>  <b>Proxy Name:</b> <i>last:</i> _____ <i>first:</i> _____ <i>middle initial:</i> _____  <b>Date of Birth:</b> _____ <b>Last Four Digits SSN:</b> _____  <b>Preferred Phone #:</b> _____  <b>Street Address:</b> _____ <b>City:</b> _____ <b>State:</b> ____ <b>Zip:</b> _____  <b>Legal Relationship to the Patient:</b> _____</p>
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I request that The Jackson Clinic & FollowMyHealth release my child's personal health information from the Jackson Clinic patient medical record to the Proxy listed above via an online FollowMyHealth account patient portal. I understand:

- If I change my mind and no longer want 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 a 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 child's Jackson Clinic record. I can receive a signed copy of this form upon request.
- For the Proxy to gain access to a child's 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.

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Signature of Proxy

\_\_\_\_/\_\_\_\_/\_\_\_\_

Today's Date