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.

	ACCOUNT ACCESS:
Purpose for Access:	☐ I am 12-17 years of age and request access to my own medical record information
	☐ I am 12-17 years of age and grant Full Access to my medical records to the authorized user below
	☐ I am 18 years or older and request access to my own medical records
	☐ **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)**
	☐ I am REVOKING proxy access to my account from the authorized user below
	☐ 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:

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	ACCOUNT ACCESS:
Purpose for Access:	☐ I am 12-17 years of age and request access to my own medical record information
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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:** _____