



## Northwell Health Proxy Request and Authorization Form for Access to ezAccess Patient Portal Minor Consent (Under 13)

If you are the parent or legal guardian of a Northwell Health patient who is under the age of 13, you can complete this form to request “proxy access” to your child’s health information in the ezAccess Patient Portal. Proxy access enables you to view some of your child’s health information in the Portal and, in some instances, communicate through the Portal with your child’s health care team. When your child turns 13, you will no longer be able to view any new information about your child in the Portal. You must complete a separate form for each child for whom you are requesting proxy access.

### Section 1. Patient (Child’s) Information: (Please Print)

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birth Sex: \_\_\_\_\_  
LAST FIRST MI MM DD YYYY

Home Address: \_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State Zip Phone \_\_\_\_\_  Cell  Home  Work

### Section 2. Requestor (Parent/Legal Guardian) Information: (Please Print)

Requestor name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
LAST FIRST MI MM DD YYYY

Requestor’s Home Address: \_\_\_\_\_  
Street Address City State Zip

Telephone #: \_\_\_\_\_  Cell  Home  Work

Telephone #: \_\_\_\_\_  Cell  Home  Work

Requestor’s Email Address: \_\_\_\_\_

Relationship to Patient (check one):

- Parent       Legal Guardian\*       Durable Power of Attorney (DPOA)\*

\*If you are the patient’s legal guardian or Durable Power of Attorney, please attach to this form copies of any legal documentation demonstrating that you are the guardian or Power of Attorney, if such documentation is not already on file in the patient’s medical record.



Power of Attorney Information on File:  Yes  No

**Patient Authorization:**

- I authorize Northwell Health to disclose the Child’s protected health information (PHI) to the ezAccess™ Patient Portal. This information includes, but is not limited to: health summary, current problem list, current medications, lab results, appointment information. This may also include, and I specifically authorize release of, information relating to 1) Acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection, 2) treatment for drug or alcohol abuse, 3) sexually transmitted diseases or 4) mental or behavioral health or psychiatric care.
- I understand that this authorization will be in effect until such time as it has been revoked, which may be done by contacting the ezAccess Support line at 212-614-0039 option 3 or by writing to the provider. Such revocation shall be effective except to the extent that action has already been taken based on this authorization.
- I understand that signing this authorization is voluntary. My child’s treatment will not be conditioned upon my authorization of this disclosure.
- Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by federal or state law.

**Proxy Designation**

- I am the parent or legal guardian of this Child.
- There are no court orders or restraining orders in effect limiting my access to this Child’s medical records and/or information.
- I understand that I may cancel this designation at any time by contacting the ezAccess Support line at 212-614-0039 option 3.
- I will establish my own ezAccess account in order to access the Child’s ezAccess Personal Health Record (PHR) account.
- I will be granted full access to the Child’s ezAccess Personal Health Record (PHR) for the Child until his/her 13th birthday at which time I will no longer receive updates to the Child’s FollowMyHealth Personal Record.

X \_\_\_\_\_  
Parent or Legal Guardian Signature                      Relationship to Patient                      Date

OFFICE USE ONLY:		
PATIENT (CHILD’S) NAME: _____	DOB _____	EPI/MRN _____
APPROVED: MANUAL INVITE SENT ON: _____	PROXY ACCOUNT CREATED ON: _____	
REJECTED _____	REASON FOR REJECTION: _____	