Northwell Health Proxy Request and Authorization Form for Access to FollowMyHealth 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 FollowMyHealth 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

_____ Phone _____ ☐ Cell ☐ Home ☐ Work
City, State Zip

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 FollowMyHealth™ 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- I understand that this authorization will be in effect until such time as it has been revoked, which may be done by contacting the FMH Support line at 844-364-8108 or by writing to the provider at the address below. 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 FMH Support line at 844-364-8108.
- I will establish my own FollowMyHealth account in order to access the Child's FollowMyHealth Personal Health Record (PHR) account.
- I will be granted full access to the Child's FollowMyHealth 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:_____