FOLLOW MY HEALTH PATIENT PORTAL INVITATION PROXY REQUEST FORM

Thank you for printing the following information:

Parent/Guardian Name: _____

Relationship to Patient(s): _____

Address: _____

_____

Email Address: _____

Phone Number: _____

By signing this form, I acknowledge and agree that:

- I am the parent or legal guardian of the above identified patient(s)
- There are no court orders or restraining orders in effect limiting my access to this child's medical records and/or information
- I am giving my permission for Cornerstone Pediatric and Adolescent Medicine to disclose the child's protected health information (PHI) through FollowMyHealth Patient Portal, which may include, but may not be limited to: the patient's health summary, current problem list, current medications, lab results, appointment information.
- I will be granted full access to the child's FollowMyHeath Personal Health Record (PHR) for the child until his/her 18th birthday, at which time I will no longer receive updates to the child's FollowMyHealth personal health record.

_____ _____

Parent/Guardian Signature Date

For Office Use Only:

Patient's Name	Patient's Date of Birth	Patient Chart # / Date Invited & Employee Initials
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