MRN__________________

495 SW Ramsey Avenue, Grants Pass, OR 97527
541-476-6644

Grants Pass Clinic FollowMyHealth
Pediatric (age 15-17 years old) Proxy Account Authorization Form

Note: Person requesting access must be patient or legal representative.

Legal Representative is a guardian, conservator, and/ or medical power of attorney.

PATIENT INFORMATION

Patient Name ______________________________ Date of Birth ______________

Mailing Address ____

City ______________________________ State __________ Zip ______________

Patient Phone ______________________________

Patient Email Address ____

PROXY INFORMATION

Parent/Legal Guardian Name ______________________________ Date of Birth ______________

Mailing Address ____

City ______________________________ State __________ Zip ______________

Phone ______________________________

Parent/Legal Guardian Email Address ____

Relationship to Patient ______________________________

Terms and Conditions

I understand that FollowMyHealth is intended as a secure online portal for viewing confidential medical information and that by giving my Proxy access I am allowing another individual access to my medical information.

I understand that FollowMyHealth contains limited, select information from a patient's record and does not reflect the entire contents of the medical record. A patient may request a copy of his/her medical record from Grants Pass Clinic.

This form only authorizes access through FollowMyHealth and does not authorize release of my medical record to my designated proxy by other methods or in other formats.

I understand that once information has been disclosed, it potentially may be re-disclosed by my proxy and the disclosed information may not be covered by federal privacy protections.

I understand that access to FollowMyHealth is provided by Grants Pass Clinic as a convenience to their patients and that Grants Pass Clinic has the right to deactivate access at any time for any reason.

I understand that this authorization will expire at age 18. I may revoke this proxy at any time, but must submit the revocation in writing to Grants Pass Clinic.

By signing below, I understand and agree to the Terms and Conditions listed above and I am the patient or legal representative. I authorize Grants Pass Clinic to send information to my proxy's Grants Pass Clinic FollowMyHealth patient portal. If you are signing as a legal representative, you must present legal documentation.

Patient/Legal Representative Signature ______________________________ **Date** ______________