MRN ______________

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

Grants Pass Clinic FollowMyHealth
Pediatric (age 0-14 years old) Parental Access Authorization

Note: Person requesting access must be parent 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 ____________

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

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 their medical records from Grants Pass Clinic.

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

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

I understand that due to privacy regulations, I will only have access to my child's record until they are age 15. From ages 15-17 it is required the patient specifically indicate whether they permit their parent(s) or guardian(s) to have access to their patient portal information via a signed authorization that will expire at age 18.

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

Parent/Legal Representative Signature ______________________________ **Date** ____________

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