Minor Child Proxy Consent

Notice: This is a HIPAA Agreement Form

Thank you for expressing interest in the FollowMyHealth® patient portal. The Hutchinson Clinic looks forward to your participation!

To request proxy access to view your child's health information using FollowMyHealth®, please complete this "Minor Child Proxy Consent." After all information is verified, you will receive a proxy email invitation from noreply@followmyhealth.com. Within this email you will also find your invitation code that has been assigned to you.

HIPAA: The federal **Health Insurance Portability and Accountability ACT** (HIPAA) of 1996, along with state law, mandates the privacy and security of Protected Health Information (PHI); the portability of health insurance and simplification of electronic billing.

- The information you are requesting access is Protected Health Information (PHI). Having access allows you to view said minor's entire PHI. The Hutchinson Clinic will not be responsible for a HIPAA breach determined to be intentional by user or occurred outside of the Hutchinson Clinic.

By completing and signing this form:

1. I certify that I am the parent/legal guardian of the patient and I have the legal right to access his or her health information.
2. I understand that any individuals I name below will have online access to personal health information, including, but not limited to, viewing portions of the health record, requesting appointments, and requesting medication refills.
3. I understand that additional information may be made available to me through the patient portal in the future.
4. I understand that this form only gives access to the patient's health record. This form does not authorize the release of the patient's medical record by other methods or in other formats. To request copies of the patient's medical record, please contact our Health Information Department.
5. I understand that access to the patient's portal is provided by Hutchinson Clinic as a convenience to its patients. Hutchinson Clinic has the right to deactivate access to the PHR at any time, for any reason.

CHILD'S INFORMATION

Name: _____ **Patient #:** _____

DOB: _____

Please note the following age range limitation for FollowMyHealth®. These age range limitations do not affect any legal right you have to access your child's record by other means. To request a paper copy of your child's record, please contact our Health Information Department.

- If your child is **0-13 years of age,** you will be granted full access to your child's FollowMyHealth® account.
- Once your child reaches **14 years of age,** you will only have access to historical information on your child's FollowMyHealth® account.
- On your child's **18th birthday,** parental/guardian access to FollowMyHealth® is automatically terminated.

PARENT/GUARDIAN INFORMATION

Name: _____ **Phone:** _____

Street Address: _____ **City, State, and Zip Code:** _____

DOB: _____ **Email Address:** _____

Relationship to Patient: ___ **Birth or Adoptive Parent** ___ **Legal Guardian***

Parent/Legal Guardian Signature: _____

*Legal Guardian's **MUST** provide a copy of legal paperwork that such person has the right to this information. Failure to submit legal paperwork will result in denial of access.

**Foster parents are not permitted proxy access or to establish FMH accounts.

ADDITIONAL PARENT/GUARDIAN ACCOUNT(S)

By completing this section, I am requesting the Hutchinson Clinic to give access to my child's PHR to the following individual(s):

Name: _____ **Phone:** _____

Street Address: _____ **City, State, and Zip Code:** _____

DOB: _____ **Email Address:** _____

Relationship to Patient: ___ **Birth or Adoptive Parent** ___ **Legal Guardian*** _____ **Other (Specify)**

For office use only:

ID Verified by (print name): _____ **Verified Legal Documentation on file: YES or NO**

Date Invitation sent: _____