REQUEST FOR PATIENT PORTAL ACCESS

Please list the names of all of your children.	Child's Date of Birth

*Patient Portal access is for all family members under the age of 18.

Parent's Name: _____

My relationship to the above children:

☐ Parent ☐ Legal Guardian (Must provide a copy of Court Order) ☐ Self – I am 18 or older

By signing below, I acknowledge and agree to the following terms:

- I must have parental rights or legal guardianship rights to access the medical records for the above listed children.
- I have not been denied custody for the above children and there are no court orders or restraining orders in effect limiting my access to the medical records for the above listed children.
- I will keep my Patient Portal log in and password confidential and will not share with anyone.
  (A separate log in will be given for each parent/guardian)
- I will only update the Patient Portal with true and accurate information.
- I understand the portal is not a complete version of my child's medical record.
- I may not use messaging through the Patient Portal for emergency situations. I will call the office directly.
- I will no longer have access to the records for the above listed children once they reach their 18th birthday unless received in writing from patient.
- All patient portal alerts will be sent to the email address I have on file with Caring Hands Pediatrics. It is my responsibility to update my email address within the portal when change occurs.

_____/_____/_____

Signature Relationship to Children Date

Email address for Patient Portal access :_____(required)

For Official Use:

Signature and identity of parent/guardian verified on _____/ Employee Signature: _____

Date

☐ **Driver's License** ☐ **Court Custody Papers Attached**