

REQUEST TO ACCESS MINOR CHILD'S INFORMATION

I am requesting access through Follow My Health portal to a minor child's health record

Please select one box below

I am the parent of a Minor patient (Photo ID required)

I am POA/Guardian/Foster parent for this patient (Copy of legal document required) (Photo ID required)

Child's Name:

FIRST NAME MIDDLE INITIAL LAST NAME

Child's DOB:

MM/DD/YYYY

Authorized User's
Name:

FIRST NAME MIDDLE INITIAL LAST NAME

Authorized User's
Email address:

Phone: _____
email address where invitation and all portal messages will be sent

I hereby authorize Lakewood Family Medicine to disclose individually identifiable health information for the above listed child to the Follow My Health patient portal giving me online access to this patient's Lakewood Family Medicine's healthcare information.

Authorized User
Signature:

Signature _____ Date: _____

For Front Desk Use Only

Photo ID Verified By: _____ Date: _____
Signature

For Portal Use Only

Copy of Legal Document
Verified and

Portal Invite sent by: _____ Date: _____
Signature

(forward paperwork to medical records for scanning to patient chart)