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 DOB: ______________________________
MM/DD/YYYY

Authorized User's Address ______________________________
Street Address

____
City State ZIP

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: ______________________________ Date: ______________
Signature

For Front Desk Use Only		
Photo ID Verified By:	______________________________ Signature	Date: ______________
For Portal Use Only		
☐ Copy of Legal Document Verified *and*		
☐ Portal Invite sent by:	______________________________ Signature	Date: ______________
(forward paperwork to medical records for scanning to patient chart)		