NORTHWELL HEALTH
PROXY REQUEST AND AUTHORIZATION FORM
FOR ACCESS TO FOLLOWMYHEALTH PATIENT PORTAL
MINOR PATIENT (UNDER 13)

If you are the parent or legal guardian of a Northwell Health patient who is under the age of 13, you can complete this form to request "proxy access" to your child's health information in the FollowMyHealth Patient Portal. Proxy access enables you to view some of your child's health information in the Portal and, in some instances, communicate through the Portal with your child's health care team. When your child turns 13, you will no longer be able to view any new information about your child in the Portal. You must complete a separate form for each child for whom you are requesting proxy access.

Section I. Patient (Child's) Information: PLEASE PRINT

Name: _____DOB: _____/_____/_____ GENDER: ☐ M ☐ F
LAST FIRST MI MM DD YYYY

Home Address:_____
Street Address

_____ Phone #_____☐Cell ☐Home ☐Work
City, State Zip

Section II. Requestor (Parent/Legal Guardian) Information: PLEASE PRINT

Requestor name: _____ Date of Birth ____/____/_____
LAST FIRST MI MM DD YYYY

Requestor's Home Address:_____
Street Address City, State Zip

Telephone #: Home_____ Cell:_____ Work:_____

Requestor's email Address:_____

Relationship to Patient (check one) ☐ Parent ☐ Legal Guardian (please attach copies of all supporting legal documentation)

Patient Authorization:

• I authorize Northwell Health to disclose the Child's protected health information (PHI) to the FollowMyHealth™ Patient Portal. This information includes, but is not limited to: health summary, current problem list, current medications, lab results, appointment information. This may also include, and I specifically authorize release of, information relating to 1) Acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection, 2) treatment for drug or alcohol abuse, 3) sexually transmitted diseases or 4) mental or behavioral health or psychiatric care.
• I understand that this authorization will be in effect until such time as it has been revoked, which may be done by contacting the FMH Support line at 844-364-8108 or by writing to the provider at the address below. Such revocation shall be effective except to the extent that action has already been taken based on this authorization.
• I understand that signing this authorization is voluntary. My child's treatment will not be conditioned upon my authorization of this disclosure.
• Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by federal or state law.

Proxy Designation

• By signing this Portal Proxy request I acknowledge and agree that:I am the parent or legal guardian of this Child.
• There are no court orders or restraining orders in effect limiting my access to this Child's medical records and/or information.
• I understand that I may cancel this designation at any time by contacting the FMH Support line at 844-364-8108.
• I will establish my own FollowMyHealth account in order to access the Child's FollowMyHealth Personal Health Record (PHR) account.
• I will be granted full access to the Child's FollowMyHealth Personal Health Record (PHR) for the Child until his/her 13th birthday at which time I will no longer receive updates to the Child's FollowMyHealth Personal Record.

X_____ _____ _____
Parent or Legal Guardian Signature Relationship to Patient Date

When complete please mail or fax to: ***Northwell Health - EMPI Department*** ***Fax: (516) 495-5993***
1983 Marcus Avenue First Floor, Suite 118
Lake Success, NY 11042

OFFICE USE ONLY:
PATIENT (CHILD'S) NAME: _____ DOB _____ EPI/MRN _____

APPROVED: MANUAL INVITE SENT ON: _____PROXY ACCOUNT CREATED ON: _____

REJECTED _____REASON FOR REJECTION:_____