Hospital *for* Special Care

We Rebuild Lives.

FollowMyHealth® Authorized Parent/Guardian Minor Patient Form

(under 18 Years of Age)

To request access to the FollowMyHealth® record of your minor child or patient for whom you have legal guardianship, please complete this form and return to **Hospital for Special Care Clinic Front Desk/Registration area**.

Patient Information

Patient Name _____ DOB ___/___/___ Email _____

Patient Phone # _____ Cell _____

Address _____ Last 4 Digits of SSN _____

Parent/Guardian Information

Parent/Guardian Name _____ Relationship _____

DOB ___/___/___ Email _____

Patient Phone # _____ Cell _____

Address _____ Last 4 Digits of SSN _____

Patient/Guardian Agreement to FollowMyHealth® Terms and Conditions

As a parent/guardian of the patient named above, I understand and agree to the following:

- FollowMyHealth® contains selected, limited medical information from the patient's medical record and does not reflect the complete contents of the medical record. A paper copy of a patient's medical record may be requested from the patient's health care provider.
- If the child is between 0 and 12 years old, then I will have full access to the child's FollowMyHealth® account.
- **If the child is between 12 and 18 years old, then I will have limited access to the child's FollowMyHealth® account.**
- **If the child is over 18 years old, then I will not have access to the child's FollowMyHealth® account, unless the patient and I complete and submit the Patient Authorized Parent/Guardian Access Authorization Form.**
- My activities within FollowMyHealth® are tracked by computer audit, and entries I make can become part of my medical record or the above-named patient's medical record.
- I understand that my access to any information about the patient may be revoked or terminated by Hospital for Special Care (HSC) at any time without notice.
- I agree to abide by the HSC FollowMyHealth® Terms and Conditions, which are available on the HSC website (www.hfsc.org)

By signing below, I acknowledge that I am authorized to access the protected health information of the patient described above. I certify that I am legally authorized to access such information about the patient named above, and that the information I have provided is true and correct.

Patient/Guardian Signature **Date** ___/___/___

FollowMyHealth® An Allscripts Solution

Health Information Management
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