



## **Patient Portal Authorization**

Please complete this form if you are the parent or legal guardian of a child under the age of 13. Any legal guardian will be required to provide documentation to show legal rights to request this access.

### **Patient Information (Please Print):**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### **Parent or Legal Guardian Information (Please Print):**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### **Relationship to Patient:**

Mother       Father       Legal Guardian

**Is there a court or restraining order that limits your access to this patient's health information?**       Yes       No

Email address: \_\_\_\_\_

Username (optional): \_\_\_\_\_  
*(If no username is provided, the computer will generate a unique username)*

I understand that the Patient Portal is not intended to provide internet based diagnostic medical services and should not be used for emergent communication. In the event of an emergency, please call 911 or visit the nearest emergency room.

By signing below, you agree to become web-enabled for the Patient Portal.

\_\_\_\_\_  
Parent or Legal Guardian Signature      Today's Date