Pinehurst Medical Clinic

PARENT/LEGAL GUARDIAN PROXY AUTHORIZATION

FOR FOLLOWMYHEALTH DEPENDENT ACCOUNT- MINOR CHILD 0-11 YEARS OLD

A parent or court appointed legal guardian may request access to their child's chart maintained in Pinehurst Medical Clinic's online Patient Portal record (hereafter referred to as FollowMyHealth) when the child is 0-11 years old subject to North Carolina law. At the time the child reaches the age of 12 years old the patient must authorize the parent or court appointed legal guardian access to their online portal record.

MINOR CHILD'S NAME (Printed Full Name): ______________________________

Date Of Birth (MM-DD-YYYY):____________________ Sex:____________ SSN: xxx-xx-________

PARENT/LEGAL GUARDIAN (Printed Full Name): ______________________________

Date Of Birth (MM-DD-YYYY):______________

Relationship (Check One): ☐Parent ☐Legal Guardian (include copy of legal guardianship document)

Address:________________________________ Email:________________________________

City:________________________________ Phone:________________________________

Zip Code:________________________________ State:________________________________

Parent/Legal Guardian's Acknowledgement- Pinehurst Medical Clinic Dependent Account (Minor's Record):

By signing below, I hereby certify and acknowledge each of the following (please read and check each box):

- ☐ I am the custodial parent or court appointed legal guardian of the minor child identified above and I am legally authorized to access their protected health information.
- ☐ There is no court order or other legal documents restricting my access to this child's medical or other protected information.
- ☐ I must have a FollowMyHealth account.
- ☐ I must log in to FollowMyHealth with my own username and password to access the minor patient's online record.
- ☐ I understand that access to the portal account will be revoked when the child turns 13 years old.
- ☐ At the time my child turns 12 years old I may request a copy of my child's medical records; however, I am not entitled to protected records related to the prevention, diagnosis and treatment of: (1) venereal or other communicable diseases; (2) pregnancy; (3) abuse of controlled substances or alcohol; or (4) emotional disturbance.
- ☐ I also agree to immediately notify the Pinehurst Medical Clinic's Privacy Office should my legal right to access my child's records changes.
- ☐ I have read and will comply with Pinehurst Medical Clinic's FollowMyHealth Terms and Conditions as posted online.

________________________________ ____________________

Signature of Parent/Legal Guardian ***Date/Time***

________________________________ ____________________

Signature of Witness ***Date/Time***

RETURN THIS FORM VIA FAX (910-235-3413) or MAIL to: Pinehurst Medical Clinic Attention: Medical Records 45 Aviemore Drive Pinehurst, NC 28374