MOUNT GRAHAM
REGIONAL MEDICAL CENTER

Adolescent Access Authorization Form

Adolescent Access to MyHealth Portal Online account for a patient between the ages of 13 and 18 years.

PATIENT'S INFORMATION
All fields are required

Patient's Name:_____ DOB: _____

Address:_____ Gender: Male _____ Female: _____

City, State, Zip: _____ PCP:_____

Telephone:_____ E-mail **(required)**_____

Please print clearly

PARENT/LEGAL GUARDIAN'S INFORMATION
All fields are required

Parent/Legal Guardian Name:_____ DOB: _____

****Only enter address if different that Adolescent**** Gender: Male _____ Female: _____

Address:_____

City, State, Zip: _____

Telephone No: _____

Parent/Legal Guardian's e-mail address (required): _____

Please print clearly

Please provide the Last 4 digits of SS#_____

Please note that the social security number is required for authentication purposes and will be stored securely in compliance with applicable law.

I understand: MyHealth Portal Online account will display <u>unlimited medial information</u> to the requestor listed below.

I have read and understand the guidleines regarding MyHealth Portal Online account information including secure patient messaging and agree to allow the requestor listed below access to my MyHealth Portal Online account information. I also agree to abide by the terms and conditions for use of MyHealth Portal Online.

_____ _____

Date Patient Signature

I authorize the adolescent patient above to create a MyHealth Portal Online account. I have read and understand the requirements for accessing the above named patient's MyHealth Portal Online account and agree to abide by these requirements.

This access will expire on the patient's 18th birthday. A photocopy of this authorization is as valid as the original. I certify that all the information I have provided is correct. I hereby request limited access to the above named patient's MyHealth Portal Online account.

_____ _____

Date Patrent/ Legal Guardian Signature