MOUNT GRAHAM
REGIONAL MEDICAL CENTER

Pediatric Proxy Authorization Form

Pediatric Proxy Access to the MyHealth Portal Online account for an child under the age of 13 years.

PATIENT'S INFORMATION
All fields are required

Patient's Name:_____ DOB: _____

Gender: Male _____ Female: _____

Only enter address if different than Pediatric Proxy requestor.

Address:_____ City, State, Zip: _____

PROXY 'S INFORMATION
All fields are required

Pediatric' s Proxy's Name:_____ DOB: _____

Address:_____ Gender: Male _____ Female: _____

City, State, Zip: _____ Proxy's Relationship to Patient:

Telephone No: _____ _____Parent _____Legal Guardian

Pediatric Proxy's e-mail address: _____
Please print clearly

Are you a MGRMC patient?

Yes_____ If yes, please provide the Last 4 digits of SS#_____

No_____ If no, please provide **entire** 9 digit SS#: _____-_____-_____

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

I have read and understand the requirements for accessing the above named patient's MyHealth Online account information and agree to abide by these requirements. I certify that all that all the information I have provided is correct. I hereby request access to the above named patient's MyHealth Online account.

_____ _____

Date Parent/ Legal Guardian Signature