# ADOLESCENT ACCESS FORM

(Adolescent access to the Your Account Patient Portal for protected health care conditions when 12-17 years of age)

**PATIENT INFORMATION**

Name: _____ Date of Birth: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Phone Number: (____)_____

Email: _____

Last 4 Digits of SSN*: _____ Gender: ___ Female ___ Male

**Required for authentication purposes*

ACCESS GUIDELINES

- For patients 12-17 years of age with a protected health care condition.
- Patient may drop off the completed form to the patient's primary site location of Adventist Health System.
- Requests are processed within 3-5 business days upon receipt.
- Portal access must be discussed with health care provider.

I have read and understand the terms of use for access to the Your Account Patient Portal. I have a protected health care condition that allows me to block my parent(s)' or legal representative's access to information about that protected health care condition. I understand
that my parent(s) or legal representative may still obtain access to my medical record through the Health Information Management Department, as permitted by law.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____