CHILD PROXY ACCESS FORM

(Child proxy access to the Your Account Patient Portal for child 0 - 17 years of age)

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Street Address: _____ City: _____

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

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

**Required for authentication purposes*

PROXY INFORMATION

Name: _____ Date of Birth: _____

Street Address: _____ City: _____

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

Email: _____

Relationship to Patient:

_____

Last 4 Digits of SSN (or entire SSN if not a patient of AHS)*: _____

**Required for authentication purposes*

ACCESS GUIDELINES

- For patients newborn to 17 years of age, unless patient has a protected health care condition and terminates proxy access.
- Only one proxy per patient account.
- Proxy access may be terminated at any time by AHS if there are access disputes between the parents or parent and child.
- Patient or proxy requestor 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.

I have read and understand the requirements for granting this proxy access. I certify that I am the parent or legal representative of the child listed on this form and that all information I have provided is correct. I hereby request access to the above named patient's Your Account Patient Portal account.

Parent/Legal Representative Signature: _____

Date: _____