FIRELANDS
Regional Health System

Adult-Child Patient Portal Proxy Sign Up

(Requesting proxy to your child's Patient Portal account)

***Parent's Information*:** (All fields required for proxy access – please print clearly)

Name: _____ Birth Date: _____
Last First Middle Initial

Street Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone # _____

Child's Information: (All fields required for child(ren) proxy access – please print clearly)

Complete this section with information about your minor child(ren) whose Patient Portal Access record you are requesting to access. If you have more than three children for whom you would like proxy access, please request another form. **Please Note that due to patient privacy laws in Ohio, a parent's proxy access to their child's patient portal account will be turned off when the patient reaches the age of 13. Please contact the Medical Records department to receive medical records for your child over the age of 13.**

A. Name: _____ Birth Date: _____
Last First Middle Initial

B. Name: _____ Birth Date: _____
Last First Middle Initial

C. Name: _____ Birth Date: _____
Last First Middle Initial

Patient Portal terms and agreement:

- I understand that Firelands Regional Health System Patient Portals are intended as a secure online source of confidential medical information. If I share my Patient Portal ID and password with another person, that person may be able to view my or my child's health information, and health information about someone who has authorized me as a Patient Portal Proxy user.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe confidentiality may have been compromised in any way.
- I understand that it is my responsibility to ensure that my e-mail address is current at all times, and that if my e-mail address is not current I will not receive important messages from Firelands Regional Health System Patient Portal(s).
- I understand that the Patient Portal contains selected, limited medical information from a patient's medical record and that the Patient Portal does not reflect the complete contents of the medical record. I also understand that a paper copy of a patient's medical record may be requested at the patient's clinic.
- I understand that my activities within the Patient Portal may be tracked electronically and that entries I make may become part of the medical record.
- I understand that access to the Patient Portal is provided by Firelands Regional Health System as a convenience to their patients and that Firelands Regional Health System has the right to end access to the Patient Portal at any time for any reason.
- I understand that my use of the Patient Portal is voluntary and I am not required to use the Patient Portal or to authorize a Patient Portal proxy.

For Patient Portal sign-up and all types of proxy access:

By signing below, I acknowledge that I have read and understand this Patient Portal Sign-Up form and agree to its terms.

_____ /_____ / _____

Your Signature *Relationship to Patient* *Date*