DRAFT

Patient Portal Consent – Access to Your Child's Record

To sign up for access to your child's record through our secure patient portal, please complete this form. Your child's chart will be accessed through your account. If you do not currently have an account, one will be created for you. Please note, your child's record may only have one managing parent/guardian at any given time and all communications will be sent only to that account manager.

Parent/Guardian Information: (All sections required)

Name (last, first, middle initial) ____

Relationship to Patient: ____

Date of Birth: ______________________ Phone Number: ______________________

Address: ____

Please provide the email address you would like them to be notified of secure messages

Email Address: ____

To avoid duplicate accounts for you and your family, tell us if you, the parent/guardian, is a patient at Village Health Partners, you may already have an account to which we will link your child's record to.

- ☐ I am patient with Village Health Partners and have a patient portal account
- ☐ I am a patient with Village Health Partners and do not have a patient portal account
- ☐ I am NOT a patient with Village Health Partners

The following are age range limitations for our secure patient portal. These age range limitations do not affect any legal right you have to access your child's record by other means. To request a paper copy of your child's record, contact our office.

- If your child is **age 0-17**, you will be granted full access to your child's record through the portal.
- Once your child reaches **age 18**, you will no longer have access to their record unless they take the required steps to request that you be granted access.

Please provide the following information for each child: (All fields are required. If you have more than 4 children for whom you are requesting access, please request another form).

A. Name (last, first, middle initial): ____
   Date of Birth: ______________________
B. Name (last, first, middle initial): ____
   Date of Birth: ______________________
C. Name (last, first, middle initial): ____
   Date of Birth: ______________________
D. Name (last, first, middle initial): ____
   Date of Birth: ______________________

- I understand that the patient portal is intended as a secure online source of confidential medical information. If I share my user ID and password with another person, that person may be able to view me or my family member's health information.
- 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 it may have been compromised in any way.
- I understand that the patient portal contains selected, limited medical information from me or my family member's medical record and that it does not reflect the complete contents of my medical record. I also understand that a paper copy of my records may be requested from the clinic.
- I understand that my activity within the patient portal may become part of my medical record.
- I understand that access to the patient portal is provided by VHP/VP as a convenience to its patients and has the right to deactivate access to the portal at any time for any reason. I understand that use is voluntary and I am not required to use the portal.
- By signing below, I acknowledge that I have read and understand this Patient Portal Communication Consent and agree to its terms.

____ ______________

Signature **Date**

Updated 12.5.2014