NEMOURS CHILDREN'S HEALTH

Patient Name:
MRN:
DOB:

* 1 0 0 0 8 5 *

Authorization for Access to Nemours Children's Health Patient Portal

I, _____ permit Nemours Children's Health to provide access to the protected health information

(PHI) related to_____,_____, through the Nemours Children's Health patient portal to:
(Patient's Name) (Patient's DOB)

_____ _____
(Enter the name of person who will have patient portal access) (Relationship to the Patient)

_____ _____
(Enter the Date of Birth of person who will have patient portal access) (E-mail)

I understand that by allowing another person access to your Nemours Children's Health patient portal, he/she will view the same information that I may view myself.

I understand that once my records have been released to my proxy, they may be re-disclosed by the proxy and will no longer be protected by federal or state regulations.

I understand that health/medical information that is released through the Nemours Children's Health patient portal may include, but is not limited to:

- Detailed diagnosis, treatment information, test results, and billing information.
- Medications that I have been prescribed.
- Upcoming and past visits, including progress notes, with a Nemours Children's Health provider.

Some information availability is dependent upon the age of the patient:

Authorization completed for:		Foster Parent (required every 3 months)		Natural Parent or Other Proxy	
Age:	0 - 11	12-17	0-11	12-17	18+
Medication Listing and Refill Requests	Yes	No	Yes	No	Yes
Progress Notes	Yes	No	Yes	No	Yes

I understand that:

- Nemours Children's Health will not condition treatment on whether I authorize the requested use or disclosure.
- If I do not sign this form, my health care and the payment for my health care will not be affected.
- I understand the information disclosed might be subject to redisclosure and no longer be protected by federal or state privacy regulations.
- If I change my mind, I have the right to revoke this authorization, in writing, at any time, by sending a written revocation to Nemours Children's Health's Privacy Officer at 10140 Centurion Parkway North, Jacksonville, Florida 32256.

This form will expire:

☐ On patient's 18th Birthday ☐ If 18 years of age, on my 26th Birthday

_____ _____
Signature of Parent, Legal Representative or Patient **Date/Time (am/pm)**

_____ _____
Print Name of Parent, Legal Representative, or Patient **Relationship to Patient**

INTERPRETER'S SIGNATURE: (To be completed only when appropriate)
I certify that I am fluent in English and the native language of the person indicating consent on the above form. I certify that I have accurately and completely interpreted the contents of this form, and that the patient and/or adult legally responsible for the minor child has indicated their understanding of the contents of this form.

_____ _____ _____ _____ AM
Interpreter's Signature Interpreter's Name (Print) Date Time PM

*Nemours includes: The Nemours Foundation, a Florida not-for-profit corporation, its operating divisions and sites, and its affiliates and subsidiaries, including Nemours Children's Hospital, Delaware; Nemours Children's Hospital, Florida; Nemours Children's Hospital, Surgery Center, Bryn Mawr; and Nemours Children's Hospital, Surgery Center, Deptford; and all entities operating under the name Nemours Children's Health.