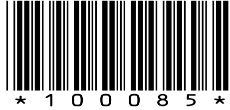

Patient Name:
MRN:
DOB:

Authorization for Access to MyNemours

I, ________________________________, permit Nemours to provide access to the protected health

Information (PHI) related to __________________________, through the MyNemours patient portal to:
(patient's name)

______________________________ (enter the name of person who will have My Nemours access)
______________________________ (relationship to the patient)

______________________________ (date of birth)
______________________________ (email)

I understand that by allowing another person access to your MyNemours 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 MyNemours patient portal may include, but is not limited to:

- Detailed diagnosis and treatment information.
- Medications that I have been prescribed.
- Upcoming and past visits with a Nemours provider.
- Test results of one or more of the following:
    - Alcohol and/or drug abuse,
    - Physical and mental illness,
    - Pregnancy,
    - Acquired Immune Deficiency Syndrome/Human Immunodeficiency Virus (AIDS/HIV) test results, or
    - Visit history about one of these conditions.

I understand that:

- Nemours 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' Privacy Officer at 10140 Centurion Parkway North, Jacksonville, Florida 32256.

This form will expire:

☐ On patient's 18th Birthday ☐ If over 18 years of age, on my 25th Birthday

______________________________ Signature of Parent, Legal Guardian, or Patient
______________________________ Date / Time (am/pm)

______________________________ Print Name of Parent, Legal Guardian, 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