

Patient Name: MRN: DOB:

Authorization for Access to Nemours Patient Portal					
l,	, pe	ermit Nemours to p	provide access to the	e protected hea	alth information
(PHI) related to	(Patient's Name	e) (Patie	, through th	ne Nemours pa	atient portal to:
(Enter the <u>name of per</u>	(Re	(Relationship to the Patient)			
(Enter the <u>Date of Birth</u> of	patient portal access)		(E-mail)		
I understand that by a the same information			to your Nemours pat	ient portal, he	/she will view
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.					
<ul> <li>I understand that health/medical information that is released through the Nemours patient portal may include, but is not limited to:</li> <li>Detailed diagnosis, treatment information, test results, and billing information.</li> <li>Medications that I have been prescribed.</li> <li>Upcoming and past visits, including progress notes, with a Nemours provider.</li> </ul>					
Some information availability is dependent upon the age of the patient:					
Authorization comple			equired every 3 months)		nt 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
<ul> <li>I understand that:</li> <li>Nemours will not condition treatment on whether I authorize the requested use or disclosure.</li> <li>If I do not sign this form, my health care and the payment for my health care will not be affected.</li> <li>I understand the information disclosed might be subject to redisclosure and no longer be protected by federal or state privacy regulations.</li> <li>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.</li> <li>This form will expire:</li> <li>☐ On patient's 18th Birthday</li> <li>☐ If 18 years of age, on my 25th Birthday</li> </ul>					
Signature of Parent,	an or Patient	Dat	Date/Time (am/pm)		
Print Name of Paren	ian, or Patient	Rela	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.					

Interpreter's Signature

Interpreter's Name (Print)

Time

Date

 $\mathsf{AM}$ 

PM