



RAUTH

Patient Portal

PARENT/LEGAL GUARDIAN PROXY ACCESS REQUEST FOR ADOLESCENT CHILD

Instruction:

Parent or Legal Guardian of an adolescent child (between the ages of 12 - 18) to complete this form to allow ChristianaCare to establish proxy access to the Patient Portal of their adolescent child. One form per parent is required. Email completed form(s) to MedicalRecordRequest@christianacare.org or Scan and fax completed form to (302) 320-4859.

PATIENT INFORMATION:

Name: _____ Date of birth: ____ / ____ / ____

Last 4-digits of SSN: _____

Address: _____

PARENT/LEGAL GUARDIAN INFORMATION:

Name: _____ Gender: _____ Date of birth: ____ / ____ / ____

Phone: (_____) _____ Cell: (_____) _____ Last 4-digits of SSN: _____

Relationship to patient: Mother Father Other: _____

Email address: _____ @ _____

Be sure to write your email address clearly

PARENT/LEGAL GUARDIAN REQUEST:

I request to have the ability to schedule appointments for my adolescent child through the Patient Portal as well as message my adolescent child's provider.

I understand that I will not be able to access any other information regarding my child through the Patient Portal. I understand that to obtain a complete copy of my medical record, I will need to request a copy through the ChristianaCare Health Information Management Services Department (detailed instructions can be found here: <https://christianacare.org/patients/medical-records/>).

I understand that my proxy access will automatically terminate on my child 's 18th birthday or I may ask to have my access terminated sooner by emailing MedicalRecordRequest@christianacare.org.

Parent/Legal Representative Signature Print Name Date ____ / ____ / ____ Time _____

Legal Representative Relationship to Patient (_____) _____
Phone Number