Patient Name:

Provider:

ENC #: **MRN #:**

DOB: **Age:**

Gender / Sex: **Appointment Date:**

Parent / Guardian Account Request Form

Person requesting access must be a parent or legal guardian

A Parent/Guardian Account allows a parent or legal guardian to have access to the UH Personal Health Record (PHR) of a patient in his/her care. To open a Parent/Guardian Account, please fill out the form below and return to your doctor's office or any UH hospital sign-in desk.

By completing and signing this form:

1. I certify that I am the parent/legal guardian of the patient and I have the legal right to access his or her health information.
2. I understand that any individuals I name below will have online access to personal health information, including, but not limited to, viewing portions of the health record, requesting appointments, and requesting medication refills.
3. I understand that additional information may be made available to me through the PHR in the future.
4. I understand that this form only gives access to the patient's PHR. This form does not authorize the release of the patient's medical record by other methods or in other formats. To request copies of the patient's medical record, please contact your doctor's office or any UH Hospital.
5. I understand that access to the patient's PHR is provided by University Hospitals as a convenience to its patients. University Hospitals has the right to deactivate access to the PHR at any time, for any reason.

PATIENT INFORMATION

First Name: ______________________ Middle Initial: _____ Last Name: ______________________ DoB: ____________

PARENT/ GUARDIAN INFORMATION

First Name: ______________________ Middle Initial: __________ Last Name: ______________________

Address: ______________________ City: ______________________ State: ____________

Zip Code: ____________ Phone Number: ______________________ Date of Birth: ____________

Email Address (Please Print): ______________________

Relationship to Patient: ☐Birth or Adoptive Parent ☐Legal Guardian* ☐Other* ______________________

Parent/Legal Guardian Signature: ______________________

*Any person signing this form other than the birth or adoptive parent of the patient MUST provide a copy of legal paperwork that such person has the right to this information. Failure to submit legal paperwork with result in denial of access.

ADDITIONAL PARENT/ GUARDIAN ACCOUNT(S)

First Name: ______________________ Middle Initial: __________ Last Name: ______________________

Address: ______________________ City: ______________________ State: ____________

Zip Code: ____________ Phone Number: ______________________ Date of Birth: ____________

Email Address (Please Print): ______________________

Relationship to Patient: ☐Birth or Adoptive Parent ☐Legal Guardian* ☐Other* ______________________

First Name: ______________________ Middle Initial: __________ Last Name: ______________________

Address: ______________________ City: ______________________ State: ____________

Zip Code: ____________ Phone Number: ______________________ Date of Birth: ____________

Email Address (Please Print): ______________________

Relationship to Patient: ☐Birth or Adoptive Parent ☐Legal Guardian* ☐Other* ______________________

Provider Office Use Only – REQUIRED INFORMATION

MRN: ______________________ Reviewer Name: ______________ Date: ______________

Practice/Office: ______________ Office Phone #: ______________ Office Email: ______________

☐ Requestor(s) Eligible for Access ☐ Requestor(s) Not Eligible for Access

Reason:

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