Blue Ridge
Pediatric & Adolescent
Medicine, Inc.

Request for Proxy Invitation to Follow My Health Patient Portal

Parent/Guardia's Name: _____

Relationship to Patient(s): _____

Address: _____
Street

_____ _____ _____
City State Zip

Phone Number(s): (_____) _____-_____ (Primary)
(_____) _____-_____ (Secondary)

Email Address: _____

Please list all children that you are requesting proxy access for:

Patient's Name	Patient's Date of Birth

By signing this Portal Proxy Request I acknowledge and agree that:

- I am the parent or legal guardian of the above patient(s)
- There are no court orders or restraining orders in effect limiting my access to this Child's medical records and/or information.
- I am giving my permission for Blue Ridge Pediatrics to disclose the Child's protected health information (PHI) through the FollowMyHealth Patient Portal, which may include, but is not limited to: health summary, current problem list, current medications, lab results and appointment information.
- I will be granted full access to the Child's FollowMyHealth Personal Health Record (PHR) for the Child until his/her 18th birthday at which time I will no longer receive updates to the Child's FollowMyHealth Personal Record.

Signature of Parent/Guardian: _____ Date: _____