Northwell Health Proxy Request and Authorization Form for Access to ezAccess Patient Portal Minor Consent (Under 13)

If you are the parent or legal guardian of a Northwell Health patient who is under the age of 13, you can complete this form to request "proxy access" to your child's health information on the ezAccess Patient Portal. Proxy access enables you to view some of your child's health information on the ezAccess Patient Portal and, in some instances, communicate through the ezAccess Patient Portal with your child's health care team. When your child turns 13, you will no longer be able to view any new information about your child on the ezaccess Patient Portal. You must complete a separate form for each child for whom you are requesting proxy access.

Section 1. Patient (Child's) Information: (Please Print)

Name: _____ DOB: _____/_____/_____ Birth Sex: _____
        LAST   FIRST   MI   MM DD YYYY

Home Address: _____
        Street Address

_____ Phone _____ ☐ Cell ☐ Home ☐ Work
City,   State   Zip

Section 2. Requestor (Parent/Legal Guardian) Information: (Please Print)

Requestor name: _____ Date of Birth ____/___/____
        LAST   FIRST   MI   MM DD YYYY

Requestor's Home Address: _____
        Street Address   City   State   Zip

Telephone #: _____ ☐ Cell ☐ Home ☐ Work

Telephone #: _____ ☐ Cell ☐ Home ☐ Work

Requestor's Email Address: _____

Relationship to Patient (check one):

☐ Parent   ☐ Legal Guardian*   ☐ Durable Power of Attorney (DPOA)*

*If you are the patient's legal guardian or Durable Power of Attorney, please attach to this form copies of any legal documentation demonstrating that you are the guardian or Power of Attorney, if such documentation is not already on file in the patient's medical record.

Power of Attorney Information on File: ☐ Yes   ☐ No

Patient Authorization:

- I authorize Northwell Health to disclose the Child's protected health information (PHI) to the ezAccess™ Patient Portal. This information includes, but is not limited to: health summary, current problem list, current medications, lab results, appointment information. This may also include, and I specifically authorize release of, information relating to 1) Acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection, 2) treatment for drug or alcohol abuse, 3) sexually transmitted diseases or 4) mental or behavioral health or psychiatric care.
- I understand that this authorization will be in effect until such time as it has been revoked, which may be done by contacting the ezAccess Support line at 212-614-0039 option 3 or by writing to the Child's provider. Such revocation shall be effective except to the extent that action has already been taken based on this authorization.
- I understand that signing this authorization is voluntary. The Child's treatment will not be conditioned upon my authorization of this disclosure.
- Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by federal or state law.

Proxy Designation
- I am the parent or legal guardian of this Child.
- There are no court orders or restraining orders in effect limiting my access to this Child's medical records and/or information.
- I understand that I may cancel this designation at any time by contacting the ezAccess Support line at 212-614-0039 option 3.
- I will establish my own ezAcess account in order to access the Child's ezAccess Portal account.
- I will be granted full access to the Child's ezAccess portal account until his/her 13th birthday at which time I will no longer receive updates to the Child's zAccess portal account.

X_____   _____ _____
Parent or Legal Guardian Signature   Relationship to Patient   Date

OFFICE USE ONLY:
PATIENT (CHILD'S) NAME: _____DOB_____EPI/MRN_____
APPROVED: MANUAL INVITE SENT ON:_____PROXY ACCOUNT CREATED ON: _____
REJECTED_____REASON FOR REJECTION:_____