PEDIATRIC PATIENT PORTAL PERMISSION

(To be provided to all patients ages 12 - 17)

Name: ______________________________________**Date of Birth** (MM/DD/YYYY): _______________

Address: ____

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E-mail Address: ____

I give permission for the following people to have access to my Archbold patient portal/medical records:

Name: _____________________________ **Relationship:** ________________________________

Name: _____________________________ **Relationship:** ________________________________

Name: _____________________________ **Relationship:** ________________________________

Name: _____________________________ **Relationship:** ________________________________

I understand:

- **My medical records may have sensitive medical information about my private visits with my doctor or medical team and by giving permission to these people, they will be able to see that medical information.**
- **I can take away this permission at any time by asking the Patient Portal Team (patientportal@archbold.org) to stop access to my information.**
- **I can still see my medical team for services, even if I do not give permission to anyone to access my paper or electronic medical information.**

I have had the chance to ask questions and understand I am giving access to these people to view and get a full copy of my medical information, even about medical services that I got without their knowledge.

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Patient Printed Name

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