Ascension Texas
Austin, TX 78723

Patient Portal Minor and Proxy Form

(Form D)

Under State and Federal law there are certain types of medical information that the parent or guardian of a minor patient age 13-17 may not view without consent of the minor patient. Because of these requirements, please complete this form to maintain or create a Patient Portal record for you and your child.

Access to your minor child's Patient Portal (Patient 13-17 years)

To sign up for access to your minor child's portal, please complete this Minor Child Proxy Form. Completing this form will establish a Patient Portal record for you and your child. You will need to submit a government issued ID for verification when completing this form.

Revocation of Proxy access to a minor child's Patient Portal (Patient 13-17 years)

To revoke Proxy access to a minor child's portal, please complete section D of this form. Completing this section will remove the proxied parent/guardian's ability to view all medical information within the said patient's portal.

A. Parent/Guardian Information (To Be completed by the individual(s) requesting access. All Sections required. Please Print Clearly.)

Full Name _____ Date of Birth _____ Sex: M / F

Street Address:_____ City:_____State:_____ Zip: _____

Last 4 of SSN: _____ Phone Number:_____ Phone Type:_____

Email Address:_____

B. Minor's Information (All Sections required. Please Print Clearly.)

Full Name _____ Date of Birth _____

Street Address:_____ City:_____State:_____ Zip: _____

Email Address (if applicable):_____

C. Patient Portal Terms and Agreement

- I understand that the Patient Portal is intended as a secure online source of confidential medical information. If I share my Patient Portal ID and Password with another person, that person may be able to view my or above minor's health information, and health information about someone for whom I have Patient Portal proxy.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner and to change my password if I believe it may have been compromised in any way.

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- I understand that access to the Patient Portal is provided by Ascension as a convenience to its patients and that Ascension has the right to deactivate access to the Patient Portal at any time for any reason. I understand that use of the Patient Portal is voluntary, and I am not required to use the Patient Portal or to authorize a portal proxy.
- I understand when the minor patient becomes 18 years of age, my access will be automatically terminated.
- By signing below, I acknowledge that I have read and understand this Patient Portal Proxy form and the Ascension Terms and Conditions, and attest that I am the parent or legal guardian of the above named minor child.

Signature of Parent/Guardian: _____Date:_____ Time: _____

Printed Name of Parent/Guardian: _____

Relationship to Child: _____

Signature of Patient: _____ Date: _____ Time: _____

Printed Name of Patient: _____

D. Revocation of Parent Access

Printed Name of Parent/Guardian: _____

Relationship to Child: _____

Signature of Patient: _____ Date: _____ Time: _____

Printed Name of Patient: _____