



* G E N C O N C T *

Minor Patient Health Portal Agreement and Consent

My signature requesting access to the following minor patient's chart attests that I am the legal parent or legal guardian. (Proof of paperwork is required if not available in the patient record before access may be granted.)

Please note the following age range invitations based on applicable state and federal law:

- You will receive full access to your child's record only if your child is between 0-11 years old.
- From the ages of 12-17, parents may still view the account, but it will cease to update, displaying only information collected prior to the child's twelfth birthday.
- This proxy access will expire when the child turns 18.

These limitations do not affect any legal right you have to access your child's medical record by other means. For information on how to obtain a copy of your child's record, please contact the Health Information Management department.

Terms and Agreement

I understand the portal access is intended as a secure online source of confidential medical information. If I share the portal username and password with any other person, that person may be able to view my or my child's health information and health information about any other person who has authorized me as a portal proxy. I agree that it is my responsibility to select a confidential password, protect my password and to change my password if I believe it may have been compromised in any way.

I acknowledge that I received and understand the terms and conditions of the Blessing Health System Portal Agreement and Consent.

Parent/Legal Guardian Name (print): _____ Date of Birth: _____

Relationship to Minor: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Child's Information (all sections required – please print clearly)

Patient Name (print): _____ Patient Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Confidential Email Address: _____

Parent/Guardian Signature: _____ Date: _____

Internal Use Only:

Patient Verification Completed By: _____ MRN #: _____