Authorization to Disclose Minor Patient (Age 12-17) Electronic Health Information to Parent/Guardian or Minor via Patient Portal

Minor Patient's Name:	Minor Patient's Date of Birth	Minor Patient's Last 4 Social Security#:
Minor Patient's Street Address:	Minor Patient's City, State, Zip:	
Minor Patient's Personal Email:	Minor Patient's Phone:	

For the parent/guardian or the minor patient to have access to the patient portal, both parties must give permission.

☐ **Parent/Guardian - I am the individual authorized to give permission to release of the above-named minor's health records for which consent to release is required, except for those records related to services for which the minor legally self-consented. I request and hereby permit Axis Health System (AHS) to release all the above-named minor's health records that are available in the patient portal account to such minor. By signing my name below, I permit AHS to release all the above-named minor's health records available on the patient portal account to such minor.**

☐ **Minor Patient – I am the minor patient authorized to give permission to release my health records related to services for which I legally self-consented. I request and hereby permit AHS to release all health records related to services for which I legally self-consented to my parent/guardian named here: _____. By signing my name below, I permit AHS to release all my health records available on the patient portal account to which I legally self-consented to my parent/guardian named above.**

Authorization: I certify that this permission is made voluntarily, and the information given is true to the best of my knowledge. I understand that by giving my permission, the parent/guardian or minor will have access to all the protected health information available through the patient portal account until the permission is canceled. I understand that I may cancel this permission at any time in writing by submitting my request in writing to the AHS Health Information Management (HIM) Department.

I understand the information in the patient portal does not include all health records related with the patient's care at AHS facilities and/or locations. I understand I may request access to the entire health record, except for those records related to services for which the minor legally self-consented or services which the parent/guardian must give permission (whichever is applicable), by contacting the HIM Department. I understand that if I need to get or permit access to the above-named minor's health records and/or need hard copies of such medical records, I must contact the HIM Department.

I understand the parent/guardian or minor will have the ability to edit, download, or share protected health information available in the patient portal account. I understand by permitting release of protected health information to a minor who is not legally required to keep it private, the information may be redisclosed by the minor and may no longer be protected.

I understand I may refuse to sign this authorization and my refusal to sign will not affect my ability to get treatment for myself or the above-named minor, enrollment, eligibility to obtain benefits, or payment. I understand I may request a copy of this signed document. If I have any questions about release of the minor's health information, I may contact the AHS Privacy Officer.

Expiration: This authorization will expire when the minor patient turns 18 years old or I request cancellation of this permission by submitting a request in writing to the HIM Department, whichever happens first.

Signature and Date

Signature: _____ Date: _____

Authorized Party's Signature (Check: ☐ Parent/Guardian OR ☐ Minor Patient)

*I attest that I am the minor patient listed above, or I attest I have legal authority to sign on behalf of the minor patient; my ability has not been limited/restricted voluntarily or through legal process. I understand legal documents may be requested for verification.

Parent/Legal Guardian, Print Name: _____ Relationship to Patient: _____

Parent/Legal Guardian, Phone Number: _____

AHS Use Only – Patient# _____

Verification: ☐ Driver's License#: _____ ☐ Other State Issued ID: _____

281 Sawyer Drive, Suite 100, Durango, CO 81303 / Phone# 970-828-2526 /Fax# 970-247-7885
HIM@axishealthsystem.org