CHILD PROXY ACCESS FORM

(Child proxy access for Hello Well™ account for child 0 - 17 years of age)

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____

Last 4 Digits of SSN: _____ Gender: _____ Male _____ Female

PROXY INFORMATION

Name: _____ Date of Birth: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____

Email: _____ Phone Number: _____

Relationship to Patient: _____

Last 4 Digits of SSN (or entire SSN if not a patient of AHS)*: _____
**Required for authentication purposes*

ACCESS GUIDELINES

- For patients, newborn to 17 years of age, unless patient has a protected health care condition and terminates proxy access.
- Only one proxy per patient account.
- Proxy access may be terminated at any time by AdventHealth if there are access disputes between the parents or parent and child.
- Patient or proxy requestor may drop off the completed form to the front desk of the patient's primary site location of AdventHealth.
- Requests are processed within 3-5 business days upon receipt.

I have read and understand the requirements for granting this proxy access. I certify that I am the parent or legal representative of the child listed on this form and that all information I have provided is correct. I hereby request access to the above named patient's Hello Well™ account.

_____ _____

Parent/Legal Representative Signature Date