Sebastopol Orthopaedics
& Sports Medicine

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Adolescent Authorization Form

*** Adolescent Access to Patient Portal account is for ages between 13 years old and 18 years of age ***

PATIENT'S (Adolescent) INFORMATION

All fields are required

Patient's Name: _____ Last 4 digits of SS#: _____ DOB: _____

Address: _____ Primary Care Physician: _____

City, State, Zip: _____ Primary Phone Number: _____

Would you like access to the Patient Portal?

☐ YES

☐ NO – I decline access to the patient portal at this time

If "yes", please provide an email address unique to you: _____

I have read and understand the Patient Portal Disclosure & Adolescent Portal Access documents provided to me by Sebastopol Orthopaedics & Sports Medicine regarding my Patient Portal account and my responsibility in safe guarding my health information. By signing I agree to only use the patient portal for non-urgent communication and will call the office for all urgent issues.

Date: _____ Patient/Adolescent Signature: _____

PARENT/LEGAL GUARDIAN'S INFORMATION

All fields are required

Parent/Legal Guardian's Name: _____ DOB: _____

Address: _____ Relationship: _____

City, State, Zip: _____ Primary Phone Number: _____

I grant access to the Patient Portal to the above listed person?

☐ YES

☐ NO – my adolescent and I do not want access to the patient portal at this time

If "yes", please provide an email address unique to parent/legal guardian: _____

I authorize the adolescent patient above to create and access their patient portal. I have read and understand the Patient Portal Disclosure & Adolescent Portal Access documents provided to me by Sebastopol Orthopaedics & Sports Medicine regarding the Patient Portal account and my responsibility in safe guarding my child's health information. By signing I agree to only use the patient portal for non-urgent communication and will call the office for all urgent issues.

Date: _____ Parent/Legal Guardian Signature: _____

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