Sebastopol Orthopaedics
& Sports Medicine

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Pediatric Proxy Authorization Form

*** Pediatric Proxy Access to the Patient Portal is for a child under 13 years of ager***

PATIENT'S INFORMATION

All fields are required

Patient's Name: _____ DOB: _____

Address: _____ Primary Care Physician: _____

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

PROXY'S INFORMATION

All fields are required

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

Address: _____ Relationship: _____

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

I am the parent or legal guardian to the above pediatric patient and would like access to the Patient Portal?

☐ YES

☐ NO – I decline/revoke access to my son/daughter's patient portal

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

I have read and understand the Patient Portal Disclosure & Patient Portal Pediatric Proxy Access documents provided to me by Sebastopol Orthopaedics & Sports Medicine regarding my Patient Portal account and my responsibility in safe guarding my health information. I certify that I am the Parent or legal Guardian of the child listed on this form and that all information I have provided is correct. I hereby request access to the above patient's portal. 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: _____

10/1/14jl