AdvocateAuroraHealth BayCare Clinic

AUTHORIZATION FOR PARENTAL ACCESS TO WEB PORTAL

(Please print)

Child's Name: _____ **Date of Birth:** _____

Address: _____
City State ZIP

Phone Number: (_____) _____

I certify that I am the (check one):

☐ Birth or adoptive parent of the above named minor ☐ Other (state relationship) _____ *(to be reviewed)*

☐ Legal guardian of the above named minor

Please select ONE Web Portal:

☐ MyAdvocateAurora (MyAdvocateAurora.org) ☐ myBayCare (my.baycare.net)

As used herein, the term "web portal" shall refer to the particular web portal selected above.

I would like to participate in the web portal. I understand that this allows me online access to my child's personal health information maintained by Advocate Aurora Health and/or BayCare Clinic which may contain protected health information created by Advocate Aurora Health or entities contracted with Advocate Aurora Health(such contracted entities can be found at the following advocateaurorahealth.org/affiliates). I also understand that messages I send **my child's** health care provider may become part of **my child's** medical record and that all entries should be truthful, accurate and concerning **my child's** health issues.

I understand that all my messages should be non-urgent. For any urgent issues requiring immediate response, I will call my child's health care provider, bring my child to the emergency department of a local hospital or call 911.

I understand that through the web portal, I will be able to:

- View selected portions of **my child's** record, such as immunizations, allergies, medications, diagnostic test results and history information, including records from Advocate Aurora affiliates that may share an electronic record with Advocate Aurora Health
- Make, review and cancel appointments for **my child**
- Communicate with **my child's** health care provider via secure messaging regarding health care concerns
- Request prescription refills for **my child**
- Pay **my child's** billing statements

I am requesting this access so I may take a more active role in **my child's** health care. I understand that any communication with providers through the web portal deals with only **my child's** health care issues and not those of friends, other family members or mine.

I understand that additional information and features may be made available to me in the future through the web portal.

I understand that I will need to create a unique user ID and a password. I am aware that I am not to share my user ID and password with anyone. The user ID and password will give me access to **my child's** personal health information. Any of **my child's** health care providers have the right to deactivate my access to the web portal for any reason. I agree to maintain my password in a secure and confidential manner.

By signing this authorization, I am requesting access to utilize the web portal for **my child.**

I understand that a written request is necessary to revoke or cancel this authorization, but in all cases my access will automatically convert to a more limited view on **my child's** twelfth (12th) birthday and will expire on **my child's** eighteenth (18th) birthday.

I have received a copy of the **Terms and Conditions** for the use of the web portal.

_____ _____ _____
Signature of Parent/Legal Guardian | Relationship | Date

_____ _____ _____
Name (please print) | Date of Birth | Email Address

_____ _____ _____ _____
Address (if different than the patient's) | City | State | ZIP

Please complete:

Have you ever been a patient of Advocate Aurora Health? ☐ Yes ☐ No

Have you ever been identified with a different name (maiden name, etc.)? ☐ Yes ☐ No Former name _____

Please mail this form to: Advocate Aurora Health- Health Information Dept
P.O. Box 0909996, Milwaukee, WI 53209-0996

Or Fax to: 414-979-2717 • **Email address:** MyAdvocateAuroraSupport@aah.org • **Phone number:** 1-855-624-9366

FOR OFFICE USE ONLY
Identity of Parent Verified: (Initials of Facility Representative _____ **Child's Medical Record No. / EPI:** _____