Parent/Guardian Account Request Form

Person requesting access must be a parent or legal guardian.

A Parent/Guardian Account allows a parent or legal guardian to have access to the UH Personal Health Record (PHR) of a patient in his/her care. To open a Parent/Guardian Account, please fill out the form below and return to your doctor's office.

By completing and signing this form:

1. I certify that I am the parent/legal guardian of the patient and I have the legal right to access his or her health information.
2. I understand that any individuals I name below will have online access to personal health information, including, but not limited to, viewing portions of the health record, requesting appointments, and requesting medication refills.
3. I understand that additional information may be made available to me through the PHR in the future.
4. I understand that this form only gives access to the patient's PHR. This form does not authorize the release of the patient's medical record by other methods or in other formats. To request copies of the patient's medical record, please contact your doctor's office or any UH Hospital.
5. I understand that access to the patient's PHR is provided by University Hospitals as a convenience to its patients. University Hospitals has the right to deactivate access to the PHR at any time, for any reason.

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____ DOB: _____

PARENT/GUARDIAN INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____ Date of Birth: _____

Email Address (please print): _____

Relationship to Patient: ☐Birth or Adoptive Parent ☐Legal Guardian* ☐Other* _____

Parent/Legal Guardian Signature:_____ Date: _____

*Any person signing this form other than the birth or adoptive parent of the patient MUST provide a copy of legal paperwork that such person has the right to this information. Failure to submit legal paperwork will result in denial of access.

ADDITIONAL PARENT/GUARDIAN ACCOUNT(S)

By completing this section, I am requesting UH to give access to the patient's PHR to the following individual(s):

First Name: _____ Middle Initial: _____ Last Name: _____
Address: _____ City: _____ State: _____
Zip Code: _____ Phone Number: _____ Date of Birth: _____
Email Address (please print): _____
Relationship to Patient: ☐Birth or Adoptive Parent ☐Legal Guardian* ☐Other* _____

First Name: _____ Middle Initial: _____ Last Name: _____
Address: _____ City: _____ State: _____
Zip Code: _____ Phone Number: _____ Date of Birth: _____
Email Address (please print): _____
Relationship to Patient: ☐Birth or Adoptive Parent ☐Legal Guardian* ☐Other* _____

(Rev. 8/20/18)

Strongsville
18181 Pearl Road Suite A200
Strongsville, Ohio 44136
Phone 440-816-4950
Fax 440-816-4960

Provider Office Use Only – REQUIRED INFORMATION:
MRN: _____ Practice/Office: Kids in the Sun- 18181 Pearl Road
Reviewer Name: Nicole Risko Office Phone #: 440-816-4950
Date: _____ Office Email: Nicole.Risko@UHHospitals.org
☒ Requestor(s) Eligible for Access ☐ Requestor(s) Not Eligible for Access
Reason: _____