Asthma & Allergy Clinic of Marin & SF Inc.

Child's Name ______________________________ **DOB** ________________

I hereby give my permission for the following individuals to have access to my child or children's medical information including but not limited to information in the chart, bringing the child (children) in for visits, drawing labs, diagnosis and treatment, immunization and other injections, and picking up prescriptions or forms.

NAME: ______________________________ **RELATIONSHIP:** ________________________

NAME: ______________________________ **RELATIONSHIP:** ________________________

Patient Portal Account

I request access to my child's Patient Health Record that is included with the Follow My Health Patient Portal located on our website (www.aasthma.com). This invitation will be sent within two weeks of completion of this form, please check your SPAM folder as it comes from a no reply address: noreply@followmyhealth.com
(Please complete all information if you would like access.)

NAME: ________________________________ **RELATIONSHIP:** ____________________

ADDRESS: ________________________ **CITY, STATE:** ______________ **ZIP:** _________

PHONE: __________________ **EMAIL ADDRESS:** ______________________________

Patient or Authorized Representative Signature: ____________________ Date: ______________

Patient or Authorized Representative Printed Name: ________________________________