

Patient Portal Registration Form and Disclosure Statement

Instructions: Complete the top and bottom sections of this form to request online access to your child's records.

FollowMyHealth Account Owner (Self/Parent)	Name: _____ (First, Last) Date of Birth: _____ Email Address: _____ Cell Phone: _____ Address: _____ _____ Last four digits SSN: _____ Relationship to Patient(s): _____
Proxy Registration (Minor Child or other Dependent)	Patient Name: _____ (First, Last) Patient DOB: _____
(Minor Child or other Dependent)	Patient Name: _____ (First, Last) Patient DOB: _____
(Minor Child or other Dependent)	Patient Name: _____ (First, Last) Patient DOB: _____

DISCLOSURE STATEMENT:

By completing this form, I understand that the above listed email address will be used to log into the Children's Health of Carolina Patient Portal from FollowMyHealth and that anyone who has access to this email account may potentially receive access to my health records or correspondence from my healthcare team at Children's Health of Carolina. I also understand that, once any health information has been uploaded to my Portal account, it is my responsibility to keep it confidential.

FollowMyHealth Account Owner Signature

Date