Springdale-Mason
PEDIATRIC ASSOCIATES, INC.

PATIENT PORTAL PROXY AUTHORIZATION FORM

I, _____ [Print Name here], date of birth _____,
Understand and acknowledge that as of my 18th birthday, my parents and/or guardians will no longer have access to my patient portal without my specific written permission.

_____ I DO grant any access to my patient portal to the names listed below. I understand that I have the right to revoke this authorization at any time by sending something in writing to Springdale-Mason Pediatrics.

_____	_____	_____	_____
Name of Parent/guardian	Relationship to you	DOB	Email address
_____	_____	_____	_____
Name of Parent/guardian	Relationship to you	DOB	Email address

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Patient Name (print) _____ Date _____

Patient Signature _____