



PATIENT INFORMATION - All	fields are required.	
Patient Name:		
MRN#:	Last 4 Digits of SS#:	Date of Birth:
City, State, Zip:		Phone #:
AUTHORIZING ACCESS FOR:		
Check box that indicates patie	ent status.	
\square Child (Birth through 11 yea	rs of age) Sign Box A	
\square Adolescent (12 through 17	years of age) Sign Box B	
☐ Adult (18 and older) Sign B	ox B	
PROXY INFORMATION - All fi	elds are required.	
Person who will be receiving a	access to patient's health information.	
_	•	Date of Birth:
Address:		
City, State, Zip:		Phone #:
Is the Proxy a Carle patient?		
- · · · · · · · · · · · · · · · · · · ·	oxy requestor has a PCP or Specialist at Ca	arle
		medical record number #
	<u>all</u> 9 digits of SS#	
	_	 purposes and will be stored securely in compliance
with applicable law.		
AUTHORIZATION SIGNATURE	<u>S</u>	
	OX A: I have read and understand the requirements for accessing the above-named patient's MyCarle Online account	
		e patient's 12th birthday. A photocopy of this
		have provided is correct. I hereby request access to
the above-named patient's My	/Carle Online account.	
	an	
		the proxy requestor listed above. I have read
-		mation including secure patient messaging and
9		ount information. I also agree to abide by the terms
•	-	of receiving any notification/alerts to my MyCarle
-	•	ations including but not limited to emails and text
messages.		5
Signature of Patient or Legal Repres	entative	Date Signed
Into mod Hoo Oct		
Internal Use Only:	un have precented in person with consider	ad application Employee's initials:
Patient or Parent/Legal Guardia Employee's location:	in have presented in person with complet Date:	ed application. Employee's initials:
	Date	