Follow My Health

Child Proxy Form

To sign up for access to your child's Follow My Health record, please complete both pages of this Child Proxy Form. This form may be completed at any West River Health Services (WRHS) location when you are able to sign in the presence of a WRHS employee. You may also mail this document to us with a copy of your driver's license as proof of identity. Mail your form to: West River Health Services, 1000 Hwy 12, Hettinger, ND 58639

Parent or Guardian Information: (All sections required-please print clearly)

Name (last, first, middle initial):____Date of Birth:______________

Last 4 digits of Social Security Number:____________________Phone Number:____________________________

Email:____

Street Address:____City:___________________________________

State:_______________________________________Zip:____

Please provide the following information for each child: (All fields are required. If you have more than six children for whom you would like proxy access, please request another form).

A. Name (last, first, middle initial):____
   Last 4 digits of Social Security Number:______________________Date of Birth:____________________

B. Name (last, first, middle initial):____
   Last 4 digits of Social Security Number:______________________Date of Birth:____________________

C. Name (last, first, middle initial):____
   Last 4 digits of Social Security Number:______________________Date of Birth:____________________

D. Name (last, first, middle initial):____
   Last 4 digits of Social Security Number:______________________Date of Birth:____________________

E. Name (last, first, middle initial):____
   Last 4 digits of Social Security Number:______________________Date of Birth:____________________

F. Name (last, first, middle initial):____
   Last 4 digits of Social Security Number:______________________Date of Birth:____________________

Please remember to complete Page 2 of this form.

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Follow My Health Terms and Agreement

- I acknowledge and agree that while Follow My Health contains a "Message Center" for patients age 18 and older, such messaging shall not be used for medical emergencies. Rather, I call 911 in the event of a medical emergency.
- I understand that Follow My Health is intended as a secure online source of confidential medical information. If I share my Follow My Health ID and password with another person, that person may be able to view my health information or my child's health information, and health information about someone who has authorized me as a Follow My Chart proxy.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.
- I understand that Follow My Health contains selected, limited medical information from a patient's medical record and that Follow My Health does not reflect the complete contents of the medical record. I also understand that a paper copy of a patient's medical record may be requested.
- I understand that access to Follow My Health is provided by WRHS as a convenience to the patients and that WRHS has the right to deactivate access to Follow My Health at any time for any reason. I understand that use of Follow My Health is voluntary and I am not required to use Follow My Health or to authorize a Follow My Health proxy.
- I understand that once my child reaches age 18, I will no longer have access to my child's Follow My Health account. My access may also be deactivated when confidential care has been provided, when my parental rights have been restricted, or when required by law.
- By signing below, I acknowledge that I have read and understand this Follow My Health sign-up form and agree to its terms.

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Signature of Parent/Guardian   Relationship to Patient   Date