FNA Fairfax Neonatal Associates, P.C. a Neonatal & Pediatric Subspecialty Group
Pediatric and Adolescent Sleep Center
AASM ACCREDITED Facility Member™
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The FollowMyHealth™ patient portal at the Pediatric Adolescent Sleep Center is designed to allow for secure patient and provider communications to our patients. Please complete and submit this form along with copies of required legal documents to authorize Pediatric Adolescent Sleep Center to email an invitation to create a portal account.

Purpose for Access:	
	PERSONAL ACCOUNT ACCESS: *(photo ID required)*
	☐ I am 18 years or older and request access to my own medical record information
	☐ I am 18 years or older and grant Read Only Access to my medical records to the authorized user listed below
	☐ I am 18 years or older and grant Full Access to my medical records to the authorized listed below
	AUTHORIZED USER ACCESS: *(copies of legal documents and photo ID required)*
	☐ I am 18 years or older and request Read Only Access to a medical record *(indicate legal status below)*
	☐ I am 18 years or older and request Full Access to a patient medical record *(indicate legal status below)*
	☐ **I have legal paperwork for POA/Guardian/Adoption/Ward of the State or County for this patient**
	☐ **I am the parent of a Minor patient aged 11 or younger and possess their birth certificate**

Patient Information *(please print)*:

Patient Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Patient DOB: _____ Phone: _____
MM/DD/YYYY

Email address where patient portal messages will be sent: _____
(PERSONAL EMAIL RECOMMENDED)

I hereby authorize Pediatric Adolescent Sleep Center to use/disclose individually identifiable health information to the FollowMyHealth™ patient portal for my online access to Pediatric Adolescent Sleep Center health care information:

Patient Signature: _____ Date: _____

Authorized User Information *(please print)*: (Person receiving access to a Patient Portal account)

Authorized User Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Authorized User DOB: _____ Relationship to Patient: _____
MM/DD/YYYY

Email address where Authorized User portal messages will be sent: _____
(PERSONAL EMAIL RECOMMENDED)

Address: _____
STREET ADDRESS CITY, STATE ZIPCODE

Home phone: _____ Cell phone: _____

Authorized User Signature: _____ Date: _____

For Front Desk Use Only	
Photo ID & Copies of Legal Documents Verified By:	Date:
For Portal Use Only	
Patient Portal Invite sent by:	Date:
(verified email address and legal documents, FMH invite sent, paperwork scanned and saved in patient chart)	