Proxy Invite Approval for Access to Online Health Record

Today's date: _______________

I give permission for Center City Pediatrics to sign me up as a "proxy" to access my child (ren)'s online health record. PLEASE PRINT TO ENSURE ACCURACY

Your First Name: ____

Your Last Name: ____

Your email Address: ____

Proxy passcode (last four digits of your oldest child's date of birth [YYYY]): _____________

Name of child (ren) Dates of Birth of child (ren):

____ ______________________

____ ______________________

____ ______________________

Relationship (circle one): Mother Father Step Mother Step Father Guardian Other: __________________

Phone Number: _________________________________

Street Address:____ Apt/Unit: ___________

City:____State:__________________Zip: ________________

Please note that this information above will be used only invite a proxy to join our patients' online health records. This information will **NOT** be updated or entered into your child (ren)'s account.

Preferred Provider: (Please Circle One)

Dr.Berger Dr.Warren Dr.Madani Dr.Fischer Dr.Robinson Dr.Frost Dr.Lee Dr.Barkan

Location: (Please Circle One) Main Office (Center City) OR Satellite Office (Bala Cynwyd)

Signature: ____