



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.Barkan
Dr.Robinson Dr.Lee Dr.Chiang, DO Amanda Naumann, CRNP

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

Signature: _____

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