PARTNERS HEALTHCARE | FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL AND MASSACHUSETTS GENERAL HOSPITAL

Practice/Provider: (or Stamp with Practice/Provider Information)

BROCKTON PEDIATRICS
65 Libby street.
BROCKTON, MA 02302

PATIENT CARE REPRESENTATIVE (PCR) ACCESS AUTHORIZATION FOR PATIENT GATEWAY APPLICATION

Step 1: One Patient per form – Print Legibly

PATIENT INFORMATION (REQUIRED)

PATIENT FULL LEGAL NAME:

LAST: FIRST:

PATIENT DATE OF BIRTH: SEX: F M AGE

PATIENT ADDRESS: STREET:

APT # CITY:

STATE: ZIP CODE:

FOR PATIENTS OVER THE AGE OF 13, CREATE A PG SELF ACCOUNT FOR TEEN? NO YES

IF YES, PATIENT'S EMAIL ADDRESS:

*(**Note**: for patients 13 to 17, a PCR must exist in order for the patient to have a PG self account. A self account generates a user ID for the teen to log in.)*

Step 2: One PCR per form – Print Legibly

PATIENT CARE REPRESENTATIVE - PCR INFORMATION (REQUIRED)

PCR FULL LEGAL NAME:

LAST: FIRST:

PCR DATE OF BIRTH: SEX: F M

PCR EMAIL:

PCR PHONE:

PCR ADDRESS: (IF DIFFERENT FROM ABOVE) SAME

PCR ADDRESS: STREET:

APT # CITY:

STATE: ZIP CODE:

HAVE THERE BEEN ANY CHANGES TO NAME OR ADDRESS IN THE PAST 12 MONTHS?

NO YES _____

DOES PCR HAVE A PATIENT GATEWAY ACCOUNT? NO YES

IF YES, USERNAME:

Authorization Received & Approved by: _____ Date: _____

PCR Identification Verification:

License State ID Passport Other Photo ID

AUTHORIZATION FOR PATIENT CARE REPRESENTATIVE ACCESS TO PATIENT GATEWAY APPLICATION

Note: The information available in Patient Gateway is a subset of information contained in the legal health record. If at any time information is needed for legal or other purposes and/or a full copy of the Patient's Medical record is needed, please contact the patient's provider directly.

I (THE PATIENT) UNDERSTAND THAT:

- I may withdraw my authorization at any time by submitting a written request to the Department or Office where I originally submitted this authorization. Authorization may be withdrawn except for the following:

  - to the extent that action has been taken in reliance on this authorization

  - if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy

- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected
- Information released on this authorization, if redisclosed by the recipient, is no longer protected by Partners HealthCare
- I understand that this authorization will remain in effect until one of the following occurs:

  - A patient 12 years or younger reaches the age of 13 years; a new authorization form is required

  - A patient reaches the age of 18 years; a new authorization form is required

  - Closure of account is requested in writing by the patient, their Legal Guardian, or Patient Care Representative

  - In the event of death of the patient or Patient Care Representative

- Partners, the patient, their Legal Guardian, and/or the patient's Patient Care Representative may elect to suspend or terminate authorization to Patient Gateway access at any time, for any reason

PATIENT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO PATIENT GATEWAY PATIENT CARE REPRESENTATIVE

CHILD/ADULT

I have carefully read and understand the above, and have had any questions explained to my satisfaction.

Patient Care Representative Signature: _____ **Date:** _____

Print Name: _____ **Relationship to patient:** _____

Print Patient's Name: _____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative: _____ **Date:** _____

Print Name: _____ **Relationship to patient:** _____

TEENS

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to the person or agency listed above for the purposes of enrollment and utilization of the Patient Gateway application.

Patient's Signature: _____ **Date:** _____

Patient Care Representative Signature: _____ **Date:** _____

Print Name: _____ **Relationship to patient:** _____