# PERSONAL HEALTH RECORD
# MINOR (AGE 12-17) AUTHORIZATION FORM

I, the undersigned, hereby authorize Jersey Health Connect to permit my parent, guardian or other individual identified below (each, a "PHR User") access to my online Personal Health Record ("PHR") which contains my Health Information. By signing this consent, I understand that each PHR User I designate below will have access to ALL of my Health Information that may be contributed by my doctors and other health care providers who participate in Jersey Health Connect. This includes Health Information that exists now, and Health Information that may be created in the future.

For purposes of this Consent, "Health Information" includes: any and all information related to my care and treatment by my health care providers, such as demographic and billing information, insurance and payment information, admission/discharge dates, current and past diagnoses, medications, allergies, and treatment provided. I understand that my Health Information may also contain, now or in the future, certain "Sensitive Information" which may include any and all legally-protected information relating to (a) a diagnosis or suspected diagnosis of HIV/AIDS, (b) sexually transmitted diseases, (c) mental health records, (d) drug and alcohol treatment information, and (e) other care or services I received/may receive as an emancipated minor under State Law (i.e., pregnancy), that the law requires my prior written consent for.

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS CONSENT and that I cannot be told that I must sign this Consent in order to receive medical treatment. If I deny Consent, my Health Information will not be available for access by a PHR User in my PHR. I understand that even if I deny Consent, my Health Information may be made available to my parent, guardian or other individual by other means unrelated to my PHR to the extent required or permitted by State law.

I understand that I can change my mind at any time by submitting a signed Withdrawal of PHR Access form to Jersey Health Connect. However, I understand that any information accessed or disclosed to the identified PHR User(s) before my Withdrawal is processed cannot be reversed or undone.

By signing below, I acknowledge that I have read this Consent, have had it explained to me, and understand and agree with all of the information presented here. I acknowledge that the terms of this Consent are, in part, governed by the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations, as may be amended from time to time ("HIPAA"), as well as New Jersey law. I understand that Jersey Health Connect and my health care providers are not responsible for any re-disclosure of my Health Information, including Sensitive Information, which may be made by any PHR User I hereby designate. I understand that this Consent shall be durable and continue in effect until I withdraw it.

_____ _____

Printed Name of Minor Individual

Signature of Minor (age 12-17) Individual

Date: ____/_____/_____

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The below undersigned PHR User(s) hereby acknowledge and agree that access may be revoked at any point in time by the Minor Individual.

Name of PHR User: _____ Relationship to Minor Individual: _____

_____ Date: ____/_____/_____

Signature of PHR User:

Name of PHR User: _____ Relationship to Minor Individual: _____

_____ Date: ____/_____/_____

Signature of PHR User:

Hospital Internal Use Only

Witness Name and Signature: _____

Notes: