

Authorization to Share Information on the Patient Portal

(for patients age 13 to 18)

I, _____ give my permission for Kaniksu Community Health to exchange information with my parent/guardian _____

Records to be released:

- Information gained through the KCH Patient Portal

This authorization will expire on the following date(s):

- One year from date
- Other, please specify: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

I, _____ revoke this permission to release my information regarding myself.

Signature: _____ Date: _____

Witness: _____ Date: _____