"My Health Portal" Proxy Access Request and Authorization Form

For help with this form, please contact the Patient Portal Help Desk at 830-778-3594

1. Patient Information:

Patient Name: _____ **Date of Birth**: _____
Last First M.I

Address: _____ **Medical Record Number:**_____
Street Address City, State Zip Code **(Optional)**

2. Proxy Information: (Person to whom you authorize Hospital to access the Patient Portal record)

Proxy Name: _____ **Date of Birth**: _____
Last First M.I.

Address: _____ **Phone Number:** _____
Street Address City, State Zip Code

Email address: _____

Does the proxy have an active Patient Portal account? Yes☐ No☐ **Has the proxy ever been a patient at Val Verde Regional Medical Center(VVRMC)and its Clinics?** Yes ☐ No☐

3. Please check one of the boxes below that best describes the proxy access requested.

(Please note that for all types of proxy access, the patient's chart will be accessed through the proxy's Patient Portal account.)

Adult Patient

Access to another adult's Patient Portal record.

(Note: This section also applies to Emancipated Minors. Emancipated Minors must provide proof of emancipation.)

Select one:

☐ **Adult-capable Adult Patient:**

- The patient should sign this form to provide authorization for release of their medical information.
- Authorization for proxy access is valid until revoked by patient.

☐ **Legal Guardian of Adult Patient:** (Adults who have a surrogate relationship with another adult through a legal arrangement.)

Select the option below that best describes the guardianship:

☐ Legal Guardian (court order)
☐ Power of Attorney for Health Care
☐ Other _____

- If you are the legal guardian or you have a durable power of attorney for healthcare for this patient, then this request must be accompanied by a copy of the legal paper work verifying your authority to have access to the patient's medical information.
- You must notify HOSPITAL immediately in case of any change in authority.

Minor Patient

Access to your minor child's Patient Portal record.

- Individuals requesting access must have parental rights or legal guardianship rights.

My Relationship to the Child is:

☐ Parent ☐ Permanent Legal Guardian of the Patient

- Must attach a copy of the Court Order Appointing Guardian and Letters of Guardianship verifying the Proxy's status as permanent legal guardian of the patient.

Select one:

☐ **Adult-Child Age 0-12 Patient:** You will be granted full access to your child's record until the child turns 13 years old.

☐ **Adult-Child Age 13-17 Patient:** (Access to your teenage child's Patient Portal record).

- HOSPITAL requires patients ages 13-17 to specifically indicate whether they permit their parent(s) or guardian(s) to have access to the portions of the patient's medical information specially protected under state laws, this includes reproductive, STD, mental health and substance abuse information, by signing a separate agreement form.
- When the patient becomes 18 years old, parent access will be turned off.

Authorization:

- By signing this proxy request, I understand that I am giving my permission for VVRMC and its clinics to disclose my protected health information (PHI) through the Patient Portal to my proxy. Information includes, but is not limited to: health summary, current problem list, current medications, lab results, appointment information.
- The information available to my proxy may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, (2) treatment for drug or alcohol abuse, (3) sexually transmitted diseases, or (4) mental or behavioral health or psychiatric care.
- This proxy request is effective until my Patient Portal account is inactivated or proxy access is revoked or expires on this specific date: _____
- This proxy request includes records that were created or existing on or before the date this form was signed, as well as records that are created after the date this form is signed.
- I understand that I have a right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing. I understand that such a revocation will not have any effect on any information already released to my proxy.
- I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Washington State privacy laws.
- I may refuse to sign this authorization and understand that my refusal to sign will not affect my ability to obtain treatment. If I refuse to sign this authorization, access to my Patient Portal account will not be granted.

By signing below, parents acknowledge and agree that:

- I will be using my own Patient Portal account at VVRMC to access the Child's Patient Portal account.
- I have parental rights or legal guardianship rights to access this Child's record.
- I have not been denied periods of physical placement with the Child and there are no court orders or restraining orders in effect limiting my access to this Child's medical records and/or information.
- Communications on behalf of the Child through Patient Portal must be sent from the Child's record and responses will be received in the Child's record. Patient Portal e-mail alerts will be sent to the e-mail address entered under Parent/Legal Guardian ("Proxy") Information.
- For a child age 0 to 12 years, I will be granted full access to the Child's Patient Portal record. On the Child's 13th birthday, I will no longer have access to the Child's Patient Portal record unless the child authorizes me to access any specially protected information - mental health, reproductive services, HIV and AIDS and chemical dependency.

Legal Guardians:

Any documents, if any, I have provided in support of my right to access the patient's protected health information, are true and correct copies and are the most recent documents related to this matter. When my legal authority to act on behalf of the patient has been inactivated, revoked, terminated, or expired, I must immediately notify VVRMC or its clinics in writing of the change in authority and mail it to the Health Information Management Dept.

Patient/Parent: By signing below, I acknowledge and agree that:

- I will comply with the terms and conditions on the Patient Portal Terms and Conditions page and this document.

X_____ _____ _____

Patient, Parent or Legal Guardian Signature (Required) | Relationship to Patient (Required) | Date (Required)

Proxy: By signing below, I acknowledge and agree that:

- I will be using my own Patient Portal account to access the patient's Patient Portal account.
- I will comply with the terms and conditions on the Patient Portal Terms and Conditions.
- The patient can revoke my access to his/her Patient Portal account at any time

X_____ _____ _____

Proxy Signature (Required) | Relationship to Patient (Required) | Date (Required)