**Scan To: Release of Information**

**PATIENT LINK PATIENT PORTAL – PEDIATRIC PROXY ACCESS REQUEST FORM** **Page 1 of 2**

All Blanks on the Form MUST be completed in Order for Proxy Access to be granted

PLACE
PATIENT IDENTIFICATION LABEL
HERE

**Patient Name:**_____ **DOB:**_____ **Last 4 of SSN:**_____

**Address – (City, State, Zip):**_____
**Phone #:** _____

I am requesting access to the above patient's PatientLink as a proxy:

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***Proxy name***: _____DOB: _____Relationship to Patient:_____

**Address – (City, State, Zip):** _____
**Phone #:** _____ **Last 4 of SSN:**_____

Please supply the ***email address of the person who will be using the patient portal***:

***Email address*** :_____

Once your information has been entered and proxy access granted, you will receive an e-mail at this address with instructions to create your own unique password to access the patient portal for CAMC

I understand that being a proxy allows online access to this patient's personal health information. The proxy will be able to view portions of the medical record, which may include information relating to sexually transmitted disease, tuberculosis (TB), hepatitis B, acquired immunodeficiency syndrome(AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that Charleston Area Medical Center will not refuse to treat me because I do not sign this authorization, unless I have agreed to receive the treatment as part of a research project or in order to provide my information to a third party. Under those circumstances, I understand that my refusal to sign the authorization may result in CAMC's refusal to treat me. Additional information may be made available to the proxy through the patient portal as Charleston Area Medical Center continues to implement this product.

By signing this authorization, I am requesting Charleston Area Medical Center to give access to me as a proxy to utilize the patient portal. I understand that Charleston Area Medical Center will require me to sign a Patient Portal User Agreement governing use of the Patient Portal. **This authorization is valid until revoked by me, or when a minor patient turns the age of 13.** I understand that a written request is necessary to revoke or cancel this authorization. However, I understand that revocation will not be effective as to uses and/or disclosures already made in reliance upon this authorization. I realize that the information used and/or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy laws. If the adult patient is incompetent, their legal representative must sign the Proxy Access Authorization Form in addition to the proxy in order for others to be granted proxy access. MPOA or other documentation may be required upon submission.

**Proxy Acknowledgement** (*Signature, Date, Time*): _____

Please submit this form ***with a copy of your photo ID***:

**1. Email** to: support.patientlink@camc.org

**2. Mail**: CAMC Health Information Management – 130-138 57th Street,(Building 3, Unit 2) Charleston, WV 25304

**3. Fax** to: (304) 388-1189

**4. At CAMC registration locations** *(Registration locations will send to Health Information Management)*

PLACE
PATIENT IDENTIFICATION LABEL
HERE

**INSTRUCTION SHEET FOR PROXY ACCESS FORM**

**WHAT IS A PROXY**: An individual who has been granted permission by the patient or the patient's legal guardian to have access to their patient health records on the CAMC Patient Portal.

**Adult Patient:** 18 years of age or older. An adult patient may grant proxy access to any other adult upon completing the Proxy Access Authorization form. If the adult patient is incompetent, their legal representative must sign the Proxy Access Authorization Form in addition to the proxy in order for others to be granted proxy access. Additional supporting documentation may be requested.

**Adolescent Patient:** Age 13 through 17 years of age. In order to support compliance with state regulatory requirements, a parent or legal guardian may **not** have proxy access to their adolescent patient's health records on the CAMC Patient Portal. The adolescent patient may be enrolled to have direct access to their patient portal, unless restricted by the adolescent's provider. The parent or legal guardian may still obtain a paper copy of the adolescent patient's health records in the Health Information Management Department by signing the appropriate release of information authorization. Additional supporting documentation may be requested. **Pediatric Minor Patient:** From birth through 12 years of age. - A parent or legal representative may have full access to their pediatric patient's health record on the CAMC Patient Portal as a Proxy until the child reaches the age of 13; the Proxy Access Authorization form must be completed. Upon the attainment of age 13, the Proxy's access will automatically be revoked, until the age of 18, at which time an adult proxy access form may be completed. Additional supporting documentation may be requested.

**ADULT PROXY FORM - 18 and older. All blanks on the form must be complete in order for proxy access to be granted.**

- **Patient Name** - Indicate the name of patient whose health information is being accessed. Include date of birth, last 4 digits of SSN and complete address.
- **Proxy Name** - The person who will be granted access to the patient's health information. Include relationship to patient, address and a complete email address. PRINT the proxy email address (it is case sensitive) clearly, as access can only be granted if the email address is correct. Include the phone number for the proxy, in case it is necessary to contact the proxy regarding proxy information. Proper identification and signature is required.
- Only one proxy and one email address can be provided on each proxy form, along with that one proxy's signature. ***If multiple people are to be granted proxy access, a separate proxy access form must be completed and signed for each proxy.***

**PEDIATRIC MINOR PROXY FORM - age 0-12 years. All blanks on the form must be complete in order for proxy access to be granted.**

- **Proxy Name** - The person who will be accessing the pediatric minor patient's health information. Relationship to patient, address and a complete email address. PRINT the proxy email address (it is case sensitive) clearly, as access can only be granted if the email address is correct. Include the phone number for the proxy, in case it is necessary to contact the proxy regarding proxy information. Proper identification and signature are required.
- Only one proxy and one email address can be provided on each proxy form, along with that proxy's signature. If multiple people are to be granted proxy access (each parent or guardian), then multiple proxy access forms must be completed, and signed.
- **Child Name, date of birth and address** - Include all information for each pediatric minor child in which this proxy will have access to.

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