CMH Community Memorial Hospital

AUTHORIZATION FOR CHILD PROXY ACCESS TO PATIENT PORTAL

Children Ages 12-17

****Proxy Access will be discontinued at the time the Child turns 18 years of age****

To sign up for access to your child's Patient Portal, please complete this child proxy form and returned to Community Memorial Hospital. Please note that your child's chart will be accessed through your Patient Portal record. Completing this form will establish a Patient Portal for you and for your child.

Parent/Guardian Proxy Information: (All sections required) *(Please print)*

Proxy's Name: _____ (first) ____ (MI) _____(last)

Date of Birth: ____ /____ /_____ Phone Number (_____) - _____ - _____ Sex: ☐ Male ☐ Female

Email Address: _____

Street Address: _____ City: _____ State: ____ Zip Code: _____

Proxy Relationship to Child: (Please check appropriate box)

☐ Parent

☐ Legal Guardian of the Patient (Must attach copy of the Court Order Appointing Guardian and Letters of Guardianship verifying the Proxy's status as permanent legal guardian of the patient)

Please take notice to the age range limitations for the Patient Portal. These limitations do not affect any legal right you have to access your child's record by any other means. These limitations are specific for Patient Portal use only. Requests for release of information can be made through CMH's Health Information Services Department.

- **Ages 0-11**: Parent/Guardian will be granted full access to child's Patient Portal record.
- **Ages 12-17**: Parent/Guardian will be not be granted access to child's Patient Portal record unless Proxy access is requested and completed by child.
- **Ages 18+**: Parent/Guardian will no longer have access to child's Patient Portal. Adult Proxy Access can be requested at this time by patient.

Child Information: (All sections required)

Child's Name: _____ (first) ____ (MI) _____(last)

Date of Birth: ____ /____ /_____ Sex: ☐ Male ☐ Female

Proxy:

By signing below I understand I will be asked to agree to the terms and conditions of use of Community Memorial Hospital's Patient Portal. I understand that I will be accessing my child's account through my own Patient Portal account.

_____ _____

Signature of Parent/Legal Guardian **Date**

_____ _____

Signature of Child **Date**

CMH Health Information Services Dept USE ONLY

Medical Record Number: _____

Identification of proxy verified? (circle one**)** **Y / N** Method (circle one) Photo ID / Compare signatures / Other :_____

Entered in Meditech: _____ Completed By: _____

Date Staff Signature/Initials