HAYSMED

Patient Portal Proxy Access Request
Minor Patient

PAWNEE VALLEY COMMUNITY HOSPITAL
HAYSMED PARTNER

Granting proxy access to your medical information in the Patient Portal:

- A minor is a person who has not yet reached their eighteenth (18th) birthday.
- A proxy is a person who can access a minor's Patient Portal account information as if they were the patient.
- For access to a minor patient's Patient Portal, a parent or legal guardian may be granted full access by proxy until the minor reaches age twelve (12). On the patient's twelfth (12th) birthday, the parent or legal guardian's access will automatically be terminated.
- A minor, age 12–17, may authorize proxy access to a parent or legal guardian by signing the authorization below (Part B). This will allow the proxy individual to view all Patient Portal information, including test results, medications, health issues, and past appointments.
- After authorizing proxy access to a parent or legal guardian, the 12–17 year old minor may revoke proxy access by completing the Proxy Revocation form.
- Proxy access to a minor's Patient Portal account is valid until revoked by the patient, the patient's death, or any statutory or regulatory requirement automatically allows the authorization to expire.
- A parent or legal guardian may contact Health Information Management to obtain the patient's medical record through release of information by calling 785–623–5824.
- A minor may also limit full access to medical records by a parent or guardian if treated for certain conditions. Contact Health Information Management at 785–623–5824.

In order for an adult proxy (age 18 or over, or legally emancipated minor) to view information in the minor's Patient Portal account, please complete the Patient and Proxy boxes below. In addition, complete the following on page 2:

- The parent or legal guardian must complete Part A for a minor patient age 0–12 years.
- The minor, age 12–17 years, must complete Part B to authorize proxy access for a parent or legal guardian.

MINOR PATIENT INFORMATION *(minor for which proxy access is requested)*

First Name:________________ Last Name:________________ Sex: ❑ M ❑ F

Date of Birth:__________ Last 4 Digits of your Social Security #:______

Address:________________________________

Previous Names (if applicable):________________ Phone #:__________

For ages 12–17 only: Child has diminished mental capacity diagnosed by their provider? ❑ Yes ❑ No

PROXY INFORMATION *(parent or legal guardian wishing to access patient information by proxy)*

First Name:________________ Last Name:________________ Sex: ❑ M ❑ F

Date of Birth:__________ Last 4 Digits of your Social Security #:______

Address:________________________________

Previous Names (if applicable):________________________________

Phone #:__________ Email Address:________________

Does the proxy already have a portal account? ❑ Yes ❑ No Relationship to Patient:______________

Please continue completing the form on page 2.

PART A
To be completed by the parent or guardian.

I, the parent or guardian of the minor patient listed on the previous page, understand the following:

- The following information is to be released: Any and all information as allowed through the Patient Portal (note: the Patient Portal may not contain the complete medical record).
- **When my child turns 12 years of age:**
  - My child can have his/her own Patient Portal account with a separate email address from mine.
  - My child, age 12–17, may sign an authorization (Part B) granting me proxy access to their Patient Portal. My child may later revoke my access without any further action from me.
  - For minors age 12–17 with diminished mental capacity, a parent or legal guardian may have access upon completion of this form with appropriate documentation in the medical record by the patient's physician.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.
- I understand that any disclosure of information carries with it the potential for an unauthorized re–disclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of the patient's health information, I can contact the Health Information Management Department at 785–623–5824.
- I understand this authorization must be filled out completely and signed, dated, and timed in order to be considered valid. My authorization may also be provided over the phone. Completion of this request will be completed within three (3) business days. I understand that I may be contacted by a staff member to verify this information.
- I represent that I am eighteen (18) years of age or older, or legally emancipated, and have the legal authority to sign this authorization.

_______________________________________ ______________________ Relationship to Patient: ❑ Parent
Signature of Parent or Legal Guardian Date/Time ❑ Legal Guardian

Proof of Legal Guardianship must be provided with this authorization or be available in the patient's medical record.

PART B
To be completed by the minor patient, age 12–17.

I authorize HaysMed and/or Pawnee Valley Community Hospital to release my medical information via the Patient Portal to the designated proxy named on the prior page.

- The following information is to be released: All information as allowed through the Patient Portal (note: the Patient Portal may not contain the complete medical record).
- I understand that I have a right revoke this authorization at any time by signing the Proxy Revocation form.
- I understand that the information in my health record may include information relating to reproductive concerns, sexually transmitted infections, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I authorize the release of these records.
- I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization.
- I understand that any disclosure of information carries with it the potential for an unauthorized re–disclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department at 785–623–5824.
- I understand this authorization must be filled out completely and signed, dated, and timed in order to be considered valid. My authorization may also be provided over the phone. Completion of this request will be completed within three (3) business days. I understand that I may be contacted by a staff member to verify this information.
- I am authorizing my parent or legal guardian listed on the previous page to have proxy access to my Patient Portal account, including access to my information such as test results, medications, health issues, and past appointments.

_______________________________________ ______________________
Signature of Minor Patient (age 12–17) Date/Time

For Office Use Only:	
❑ Verbal consent obtained via phone by Associate:____________________ Date/Time: ____________________ Date Enrolled:______________ Initials: ______________	