THREE RIVERS HOSPITAL

Patient Portal PROXY Authorization

Please **PRINT** demographic information **as clearly as possible**.

The accuracy of this information helps ensure the correct person is provided authorization to access your Three Rivers Hospital Patient Portal.

PATIENT Info

Have you completed a PATIENT PORTAL Registration form? ❑ No ❑ Yes

LAST Name: _____ **FIRST** Name: _____ **MIDDLE** Initial: _____

Date of Birth: ____/____/_____ (mm / dd / yyyy) **Phone**: (_____)_____ (Home Cell Work Other) Med Record # _____ *Optional*

Address 1: _____ (**Mailing** address) _____ (City) _____ (State) _____ (Zip code)

ACCESS by PROXY Information

(The person authorized to access the PATIENT's health care information with Three Rivers Hospital)

LAST Name: _____ **FIRST** Name: _____ **MIDDLE** Initial: _____

Date of Birth: ____/____/_____ (mm / dd / yyyy) **Gender**: ❑ M ❑ F Preferred Language: _____

Address 1: _____ (**Mailing** address) _____ (City) _____ (State) _____ (Zip code)

Phone: (____)_____ (Home) (____)_____ (Cell) **Email**: _____ @ _____

Does your Proxy have an active Patient Portal account with Three Rivers Hospital? ❑ No ❑ Yes *MR # ?*_____

Has the Proxy been a patient at Three Rivers Hospital in the past? ❑ No ❑ Yes

ADULT

Access to another adult's electronic health record.

❑ *This section also applies to **Emancipated Minors***
(Copy of proof of Emancipation must be attached to this form)

❑ Adult-capable Adult

The **Patient must sign this form** to provide authorization for release of their medical information.

♦ *Authorization for proxy access is valid until revoked by the Patient.*

❑ Guardian of Adult

Mark category of Guardianship:

❑ **Legal Guardian;** court ordered

❑ **Power of Attorney** for
- ❑ Healthcare
- ❑ Other: _____

Copy of legal document verifying your authority/guardianship must be attached to this Authorization release.

You must notify Three Rivers Hospital IMMEDIATELY in the event your authority/guardianship status changes for this Patient.

MINOR / CHILD

Access to a minor child's Patient Portal information.

My relationship to the child is:

❑ ***Parent***

❑ ***Permanent Legal Guardian of the Patient***
(Copy of Court Order Appointing Guardian and Letters of Guardianship verifying the Proxy's status as permanent legal Guardian of the Minor/Child must be attached to this form)

❑ Newborn - 12 years old

You will be authorized to full access to your child's health care information with Three Rivers Hospital until the child turns 13 years old.

♦ *If you have also been a patient with Three Rivers Hospital, your child's record will be accessible through your Patient Portal access point.*

♦ *When the Patient turns 13 years old, by state law, they can choose whether parent/guardian can access to their Patient Portal. If continued access is desired by both Patient and Proxy, a new Proxy Authorization form can be completed.*

❑ 13 - 17 years old

Patients of 13 - 17 years old can choose to permit whether their parent(s) or guardian(s) are authorized to access portions of their health care information specially protected under state laws; this includes reproductive, STD, mental health and substance abuse information.

♦ *When the Patient becomes 18 years old, parent/guardian access to their Patient Portal will be disconnected. If continued access is desired, a new Proxy Authorization form can be completed after they turn 18 years old.*

To be completed by the PATIENT

who is authorizing additional access to their health care information at Three Rivers Hospital.

(Does not apply to Legal Guardian, Power of attorney, or Newborn to 12 years old)

AUTHORIZATION for ACCESS

to my personal PATIENT PORTAL

- By signing this proxy request, I understand that I am giving my permission for Okanogan Douglas District Hospital, dba Three Rivers Hospital, 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 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.

Adult Patient / Legal Guardian / Parent

By signing below, I acknowledge and agree to comply with the terms and conditions on the Patient Portal **Terms and Conditions** and this document.

X _____

Patient, Parent or Legal Guardian Signature ***(Required)***

_____

Relationship to Patient ***(Required)***

_____

Date ***(Required)***

To be completed by the PROXY

REMINDER: Copy of any legal documents must be attached to this form when submitted for processing.

Incomplete forms will not be accepted.

By signing below, parents acknowledge and agree:

- I will be using my own Patient Portal account at Three Rivers Hospital 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 the 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 zero 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

All documents, if any, I have provided in support of my request 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 Three Rivers Hospital in writing of the change in authority & the date it became effective, and mail it to Three Rivers Hospital, ATTN: Health Information Management, PO Box 577, Brewster, WA 98812

Proxy

By signing below, I acknowledge, agree & understand:

- I will be using my own Patient Portal account to access the patient's Patient Portal account.
- I will comply with 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)***

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