MY RH HEALTH

Patient Portal and Proxy Access Request and Authorization Form

Upon completion, take this form along with your valid photo ID to the medical records department located on the ground floor of Rivers Health.
The medical records department is open Monday through Friday from 7:30 a.m. to 3:30 p.m.

1. **Patient Information:**

Patient Name: _____ Date of Birth: _____
First Middle Initial Last

Address: _____ XXX-XX- ___ ___ ___ ___
Street Address City, State Zip Code Social Security Number (last 4 digits)

Email address: _____ Phone: _____

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

2. **Proxy Information: (person to whom you authorize Rivers Health to release the Patient Portal record)**

Proxy Name: _____ Date of Birth: _____
First Middle Initial Last

Address: _____ _____
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 Rivers Health? Yes No

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 patient record *(Note: This section also applies to emancipated minors. Emancipated minors must provide proof of emancipation.)*	**Minor Patient** Access to your minor child's patient portal record *(Note: Individuals requesting access must have parental rights or legal guardianship rights.)*
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 health care for this patient, then this request must be accompanied by a copy of the legal paperwork verifying your authority to have access to the patient's medical information. • You must notify Rivers Health immediately in case of any change in authority.	**My relationship to the child is:** _____ Parent _____ Permanent legal guardian of the patient. Must attach a copy of the court order appointing guardian or letters of guardianship verifying the proxy's status as permanent legal guardian of the patient. **Select one:** _____ Adult-child age 0-13 patient: you will be granted full access to your child's record until the child turns 14 years old. _____ Adult-child age 14-17: access to your teenage child's patient portal record. • Rivers Health requires patients ages 14-17 to specifically indicate whether they permit their parents(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.

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 or her patient portal account at any time.

X _____ _____ _____
Patient, Parent or Legal Guardian Signature (required) Relationship to Patient (required) Date

RIVERS HEALTH
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