Mon Health
Stonewall Jackson Memorial Hospital
Vandalia Health

HealtheLife Patient Portal – Adult Proxy

Access Request Form

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

Address – (City, State, Zip): _____

Phone #: _____

I authorize the **following individual to have access** to my HealtheLife account 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 SJMH.

I understand that my Proxy will have the same access and privileges that I have for the Patient Portal. I understand that this allows my Proxy online access to my personal health information. My Proxy will be able to view portions of my record that I am able to view, 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 Mon Health Stonewall Jackson Memorial Hospital 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 MHMC's refusal to treat me. I also understand that additional information may be made available to my Proxy through the patient portal as Mon Health Stonewall Jackson Memorial Hospital continues to implement this product.

By signing this authorization, I am requesting Mon Health Stonewall Jackson Memorial Hospital to give access to my Proxy to utilize the patient portal. I understand that Mon Health Stonewall Jackson Memorial Hospital will require my Proxy to sign a Patient Portal User Agreement governing use of the Patient portal. This authorization is valid until revoked by me. 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. If no expiration date given, this access will expire when the pediatric patient turns 13, or when the adult patient revokes the access.

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

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

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

1. **Email** to: SJMH_ROI@vandaliahealth.org
2. **Mail**: SJMH Health Information Management Attn: HIM Proxies – 230 Hospital Plaza, Weston, WV 26452
3. **Fax** to: (304) 269-8148
4. **At SJMH registration locations** (*Registration locations will send to Health Information Management*)

All Blanks on the Form MUST be completed in Order for Proxy Access to be granted. Please print legibly.

Patient label

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Instruction Sheet

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 SJMH 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.

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 SJMH 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.

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 SJMH 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 atomically be revoked, until the age of 18, at which time an adult proxy access form may be completed.

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

- **Patient Name –** Indicates 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 of 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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