Mon Health
Stonewall Jackson Memorial Hospital
Vandalia Health

HealtheLife Patient Portal – Pediatric Patient Proxy

(patient ages newborn through, and including, 17)

Access Request Form

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

Address – (City, State, Zip): _____

Phone #: _____

I am requesting access to the above patient's HealtheLife Patient Portal 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 SJMH patient portal.

Certain Health information may be omitted from the patient portal due to the technical infeasibility of separating certain sensitive records. Additional information may be made available to the proxy through the Health Information Management (HIM) department.

By signing this request form, I attest that I am the parent of the pediatric patient, and that I have not had parental rights terminated. I request that SJMH give access to me as a proxy to utilize a pediatric patient's patient portal. I understand that SJMH will require me to sign a Patient Portal User Agreement governing use of the patient portal. I understand that documentation of my relationship to the pediatric patient may be required to support this request for proxy access.

If granted, proxy portal access will automatically end when the pediatric patient reaches age 18

Additional Attestation Needed Prior to Releasing Records for Patients 12-17 Years Old

I Attest by my signature below that none of the following apply to the child for which I am requesting records. I also attest that I will notify SJMH should any of the following apply at any time prior to the patient's 18th birthday:

(1) The minor child has graduated high school or equivalent
(2) The minor child is emancipated; or
(3) The minor child is married.

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 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 is not the patient who has been given permission to access the patient's health records on the SJMH Patient Portal**.**

Pediatric Minor Proxy Form- age 0-17 years. All blanks on the form must be completed 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), then multiple proxy access forms must be completed, and signed.

- **Child Name, date of birth and address –** Complete and accurate information must be provided for proxy request to be processed.

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

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