

MY PVH 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 Pleasant Valley Hospital. 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 Pleasant Valley Hospital 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 Pleasant Valley Hospital? 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	Minor Patient
Access to another adult patient record <small>(Note: This section also applies to emancipated minors. Emancipated minors must provide proof of emancipation.)</small>	Access to your minor child's patient portal record <small>(Note: Individuals requesting access must have parental rights or legal guardianship rights.)</small>
Select one:	My relationship to the child is:
<input type="checkbox"/> Adult-capable adult patient <input type="checkbox"/> The patient should sign this form to provide authorization for release of their medical information. <input type="checkbox"/> Authorization for proxy access is valid until revoked by patient.	<input type="checkbox"/> Parent <input type="checkbox"/> 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.
<input type="checkbox"/> Legal guardian of adult patient <small>(adults who have a surrogate relationship with another adult through a legal arrangement)</small>	Select one:
Select the option below that best describes the guardianship:	<input type="checkbox"/> Adult-child age 0-12 patient: you will be granted full access to your child's record until the child turns 13 years old.
<input type="checkbox"/> Legal guardian – court order	<input type="checkbox"/> Adult-child age 13-17: access to your teenage child's patient portal record.
<input type="checkbox"/> Power of attorney for health care	<input type="checkbox"/> Pleasant Valley Hospital requires patients ages 13-17 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.
<input type="checkbox"/> Other	<input type="checkbox"/> When the patient becomes 18 years old, parent access will be turned off.
<input type="checkbox"/> 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.	
<input type="checkbox"/> You must notify Pleasant Valley Hospital immediately in case of any change in authority.	

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

