Scan to: Release of Information

PATIENT LINK PATIENT PORTAL – ADULT PROXY

(patient age 18 and older)

ACCESS REQUEST FORM

All Blanks on the Form MUST be completed in Order for Proxy Access to be granted

Charleston Area Medical Center

PLACE
PATIENT IDENTIFICATION LABEL
HERE

Please print legibly

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

Address – (City, State, Zip): _____

Phone #: _____

I authorize the **following individual to have access** to my PatientLink 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 CAMC.

I understand that my Proxy will have the same access and privileges that I have for the Patient Portal and will be able to view all portions of my medical record that I am able to view, including, but not limited to, information concerning sexually transmitted infection, mental health services, pregnancy and family planning services, and treatment for alcohol and drug abuse.

I understand that certain health information may be omitted from the patient portal due to the technical infeasibility of separating certain sensitive records.

I also understand that additional information may be made available to my Proxy through the patient portal as CAMC continues to implement this product.

Certain health information may be omitted from the patient portal due to the technical infeasibility of separating certain sensitive records.

By signing this authorization, I am requesting CAMC to give access to my Proxy to utilize the patient portal. I understand that CAMC 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. Proxy access may be removed at any time by the patient or legal representative by calling 877-621-8014 and providing name and date of birth. However, I understand that revocation will not be effective as to uses and/or disclosures already made in reliance upon this authorization. Once the information is disclosed to my Proxy, it potentially may be redisclosed by my Proxy and may not be covered by federal privacy protections.

If the adult patient is legally incapacitated, their legal representative must sign this form on behalf of the patient, in addition to the Proxy. Legal documentation may be required upon submission.

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

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

1. **Email** to: support.patientlink@camc.org
2. **Mail**: CAMC Health Information Management Attn: HIM Proxies –130-138 57th Street,(Building 3, Unit 2) Charleston, WV 25304
3. **Fax** to: (304) 388-1325
4. **At CAMC registration locations** *(Registration locations will send to Health Information Management)*

PLACE
PATIENT IDENTIFICATION LABEL
HERE

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 CAMC 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.

ADULT PROXY FORM - 18 and older

All blanks on the form must be complete in order for proxy access to be granted.

- **Patient Name** - Indicate 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.***

Any **proxy access may be removed** by the patient or legal representative by calling **877-621-8014** and providing name and date of birth.

Please submit this form ***with a copy of your photo ID***:
1. Email to: support.patientlink@camc.org
2. Mail: CAMC Health Information Management Attn: HIM Proxies –130-138 57th Street,(Building 3, Unit 2) Charleston, WV 25304
3. Fax to: (304) 388-1325
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