Charleston Area Medical Center

Scan To: Release of Information

PLACE
PATIENT IDENTIFICATION LABEL
HERE

PATIENT LINK PATIENT PORTAL – PEDIATRIC PATIENT PROXY

(patient ages newborn through 11)

ACCESS REQUEST FORM

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

Please print legibly

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

Address – (City, State, Zip):_____
Phone #: _____

I am requesting access to the above patient's PatientLink as a proxy:

++

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 being a proxy allows online access to this patient's personal health information. The proxy will be able to view portions of the medical record, 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.

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 patient portal as CAMC continues to implement this product.

By signing this authorization, I am requesting CAMC to give access to me as a proxy to utilize the patient portal. I understand that CAMC will require me to sign a Patient Portal User Agreement governing use of the patient portal.

This authorization is valid until revoked or when a minor patient turns the age of 12. Documentation of legal rights may be required to support this request for proxy access. Please be advised that appliable state and federal law contains privacy protections that may impact foster parents' and adoptive parents' ability to access a minor's medical records through the CAMC Patient Portal.

Proxy 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)*

PATIENTLINK PATIENT PORTAL – PEDIATRIC PATIENT PROXY ACCESS REQUEST FORM

(patient ages newborn through 11)

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.

PEDIATRIC MINOR PROXY FORM - age 0-11 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 or guardian), then multiple proxy access forms must be completed, and signed.
- **Child Name, date of birth and address** - Include all information for each legal minor child to which this proxy will have access.
- **Proxy may be removed at any time by calling 877-621-8014.**

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)*