



Scan to: [Release of Information](#)

PATIENT LINK PATIENT PORTAL – ADOLESCENT D5 H9 BH PROXY

(1 22) 0 8ges 12 A @ [~ * @ 7)

ACCESS REQUEST FORM

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

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:

+++++

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 access and privileges to the Patient Portal and will be able to view all portions of my medical record, 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 through the patient portal and to my proxy as CAMC continues to implement this product.

Please submit this form:
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 – ADOLESCENT PATIENT
PROXY ACCESS REQUEST FORM**

(patient ages 12 through 17)

PLACE
PATIENT IDENTIFICATION LABEL
HERE

By signing this authorization, I am requesting CAMC to give access to my Proxy to access and utilize my 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 may be removed at any time by calling 877-621-8014.** 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.

I understand that only a parent or legal representative with appropriate documentation will be authorized proxy access. Therefore, the requested proxy may be required to provide documentation upon submission.

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

Patient signature must be witnessed by:

Signature of treating provider _____

Or

Signature of Notary:

I, _____, a Notary Public in and for the County and State aforesaid, do hereby certify that _____, whose name is signed to the writing hereto annexed, bearing date the ____ day of _____, 2024, has this day acknowledged the same before me in my said County.

Given under my hand this date: _____

My commission expires: _____

Notary Public Signature

**PATIENTLINK PATIENT PORTAL – ADOLESCENT PATIENT
PROXY ACCESS REQUEST FORM**

(patient ages 12 through 17)

PLACE HERE
PATIENT IDENTIFICATION LABEL

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.

Adolescent Patient: Age 12 through 17 years of age.

Proxy may be removed at any time by calling 877-621-8014.

ADOLESCENT PROXY FORM - 12 through 17. 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.***

Please submit this form :

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*)