Scan to: Release of Information

PATIENT LINK PATIENT PORTAL – ADOLESCENT D5 H9 BH PROXY

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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:

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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 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

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 me 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: ________________________________

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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.***

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