St. Luke Community Healthcare

*The **HEART** of the Mission Valley*

PORTAL PROXY REGISTRATION FORM

PATIENT INFORMATION		
Name: (Last)_____	(First)_____	(Middle Initial)____
Date of Birth:_____	Last 4 digits SS#_____	
Address: (Street)_____	(City/State)_____	(Zip)_____
E-mail Address:_____	Phone:_____	

PROXY INFORMATION		
Name(Last)_____	(First)_____	(Middle Initial)____
Date of Birth:_____	Last 4 digits SS#_____	
Address: (Street)_____	(City/State)_____	(Zip)_____
E-mail Address:_____	Phone:_____	
Indicate if proxy has an active patient portal account: (circle) YES NO		
Indicate if proxy has ever been a patient at St. Luke Community Healthcare: (circle) YES NO		
*********You will be granted access to your child's record through the Portal until the child turns twelve years old*****		

Please check one of the boxes that best describes the proxy access requested

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____	Adult-capable adult patient (Age 18 or>)	The patient should sign this form to provide authorization for release of their medical information. The authorization for proxy access is valid until revoked in writing by the patient. This section also applies to emancipated minors. Emancipated minors must provide proof of emancipation.
____	Adult patient with legal guardian (Age 18 or >)	Adults who have a surrogate relationship with another adult through a legal arrangement. If you are the legal guardian or have a durable power of attorney for healthcare ***(with current authority)*** for this patient, a copy of the legal paperwork must be attached.
____	Minor patient parent (Age 0-11)	Individuals requesting access must have parental rights
____	Minor patient permanent legal guardian (Age 0-11)	Individuals requesting access must attach or have on file, a copy of the Court Order Appointing Guardian and Letters of Guardianship verifying the Proxy's status as permanent legal guardian of the patient.

St. Luke Community Healthcare Portal Proxy Registration Form (continued)

Authorization:

- By signing this proxy request, I understand that I am giving my permission for St. Luke Community Healthcare to disclose my Protected Health Information through the Patient Portal to my Proxy. Information includes, but is not limited to: health summary, current problem list, current medications, lab results, appointment information, and provider/nurse messaging.
- The information available to my proxy may include information relating to (1) Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, (2) treatment for drug or alcohol abuse, (3) sexually transmitted diseases, or (4) mental or behavioral health or psychiatric care.
- This proxy request includes records that were created or existing on or before the date this form was signed, as well as records that were created after the date this form is signed.
- I understand that I have the right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing. I understand that such a revocation will not have any effect on information already released to my proxy.
- I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Montana State privacy laws.
- I may refuse to sign this authorization and understand that my refusal to sign will not affect my ability to obtain treatment. If I refuse to sign this authorization, access to my Patient Portal account will not be granted.

By signing below, parents acknowledge and agree that:

- I will be using my own Patient Portal account at St. Luke Community Healthcare to access the child's account.
- I have parental rights or legal guardianship rights to access this child's account.
- I have not been denied periods of physical placement with the child and there are no court orders or restraining orders in effect limiting my access to this child's medical records and/or information.
- Communication on behalf of the child through the Patient Portal must be sent from the child's records and responses will be received in the child's record.
- Patient Portal e-mail alerts will be sent to the e-mail address entered under the Parent/Legal Guardian (Proxy) information.
- I will be granted full access to the child's Patient Portal record. On the child's 12th birthday, I will no longer have access to the child's record through the Patient Portal.

Legal Guardians:

Documents that I have provided in support of my right to access the patient's Protected Health Information, are true and correct copies and are the most recent documents related to this matter. When my legal authority to act on behalf of the patient has been inactivated, revoked, terminated, or expired, I must immediately notify St. Luke Community Healthcare in writing of the change in authority and mail it to the Health Information Department.

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 the terms of this Portal Proxy Registration Form.

X_____

Patient, Parent or Legal Guardian Signature Relationship to Patient Date

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 page and the terms of this Portal Proxy Registration Form.
- I understand that the patient can revoke my access to his/her Patient Portal account at any time.

X_____

Patient, Parent, or Legal Guardian Signature Relationship to Patient Date

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State of_____ County of_____

This instrument was signed or acknowledged before me on _____by_____

Month/day/year *Print name of signer*

Affix Seal/Stamp

_____

Notary Public Signature