PATIENT PORTAL PROXY ACCESS FORM: ADULT

To sign up for access to another Adult's health information through the Patient Portal, please complete this form in its entirety. The adult's electronic medical record account will be linked to your current patient portal account (if available). This will allow you to have a proxy access to their health information available in CBHA's Patient Portal, a part of our electronic medical record solution "AthenaPractice" by Athena Health.

After this form has been filled out, please return it to CBHA (address and fax number below). An activation code and link to complete the registration process online will be sent to you.

1. **("Proxy") Information:** The Proxy must be a CBHA patient and needs to also enroll in the Patient Portal, if not already completed.

Name (last, first, middle initial) ___________________________________ Date of Birth _______________________

Address ____

City ____ State _________ Zip _________ Phone _________________

Email ____ Primary Provider ___________________________________

2. **Proxy Access Request: Adult:** My Relationship to the adult is as follows:

   _____________ Parent

   _____________ Spouse

   _____________ Power of Attorney/Other *(Must attach a copy of the Court Order appointing Power of Attorney of Medical Decision Making or Court Appointed Representative)*.

3. **Age Range Limitations:**
   - Ages 0 – 11, you will be granted full access to his/her medical records available in CBHA's Patient Portal.
   - Ages 12-17, you will **not** be granted full access to his/her medical records **unless** this "Patient Portal Proxy Access Form: Child/Teen" is signed by both requesting proxy and child/teen patient.
   - Ages 18 and over, you will **not** be granted full access to his/her records **unless** a "Patient Portal Proxy Access Form: Adult" is signed by both requesting proxy and adult patient.

   These limitations do not affect any legal right to request paper or digital copies of medical records as allowed by Federal and Washington State Privacy Laws by other means. To do so, please contact CBHA's Medical Records department.

4. **Proxy Acknowledgements:** By signing below, I acknowledge and agree that as a proxy:
   - I will be using my own CBHA Patient Portal account to access this Adult's records.
   - I will keep my password confidential and not share this information with anyone.
   - There are no court orders or restraining orders in effect limiting my access to this Adult, their medical records and/or information.

____ ___________________________ _____________________

Proxy Signature (Required) Relationship to Patient (Required) Date (Required)

5. **("Patient") Information:**

Name (last, first, middle initial) ____Date of Birth _________

Address ____

City _____________________________________ State _________ Zip _________ Phone _____________

Email ______________________________________ Primary Provider ____________________________

6. **Adult Patient Acknowledgement:**

- I understand that CBHA's Patient Portal record disclosures covered under this proxy form **includes ALL records**, including information that would otherwise be protected from (not disclosed to) anyone without my consent according to Federal and Washington State Privacy Laws.
- ***(REQUIRED)*** My **initials** below specifically authorize the release of healthcare information relating to the testing, diagnosis, or treatment for:

❑ HIV/AIDS Virus ____________________ ❑ Mental Health/Psychiatric Disorders _________________

❑ Sexually Transmitted Diseases ____________ ❑ Drug, Alcohol Abuse/Treatment ________________

- I understand that I am not required to designate a Patient Portal account proxy and I am not required to provide this authorization. I also understand that CBHA does not base any of my health care treatment, payment or other services on whether I provide this authorization. I also understand that if I do not provide authorization, CBHA is not permitted to provide access to my Centricity record to the requestor of this proxy.
- I authorize release of this information only through my Patient Portal records. This form does not authorize release of my medical record to my designated proxy by other methods or in other forms. I understand that once information has been disclosed, it potentially may be re-disclosed by the proxy, and the disclosed information may not be covered by federal privacy protections.
- I understand **this form may be revoked at any time**, providing the information has not already been disclosed, by submitting a request in writing to terminate the Proxy's access. I also understand that revoking this authorization will not affect any disclosures that were made prior to processing the revocation request.

I acknowledge that I have read and understand this sign-up form. I agree to its terms and choose to designate the person named above (the proxy/grantee) as my proxy, thereby allowing him/her to access my CBHA Patient Portal medical records.

____ __________________________ ________________

Patient Signature (Required) Relationship to Proxy (Required) Date (Required)

Fax Completed form to **(509) 331-1601** or mail to:
Columbia Basin Health Association
1515 E. Columbia Street
Othello, WA 99344

Please send all Proxy requests lo Medical Records lo be processed.

For Official Use:
I have received I copy d the required guardianship and/or Durable Power of Attorney for healthcare verification.

Date: ___________________ Initials: _________________