PATIENT PORTAL PROXY ACCESS FORM: CHILD/TEEN

To sign up for access to your child/teen's health information through the Patient Portal, please complete this form in its entirety. Your child/teen'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 your child/teen's health information available in CBHA's Patient Portal, 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. **Parent/Legal Guardian ("Proxy") Information:** The Proxy must be a patient of CBHA 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 to Child/Teen:** My Relationship to the child/teen is as follows:

   _____ Parent

   _____ Permanent Legal Guardian of the Patient *(Must attach a copy of the Court Order Appointing Guardian and Letters of Guardianship verifying the Proxy's status as permanent legal guardian of the patient).*

3. **Age Range Limitations:**

- Ages 0 – 11, you will be granted full access to his/her medical records available in CBHA's AthenaPractice EMR solution.
- 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 your child/teen's records as allowed by Washington State Minor Consent and 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 Child/Teen's records.
- I will keep my password confidential and not share this information with anyone.
- I must have parental rights and legal guardianship rights to access this child/teen's record.
- I have not been denied periods of physical placement with the Child/Teen and there are no court orders or restraining orders in effect limiting my access to this Child/Teen's medical records and/or information.

_____ _____ _____

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

5. Child/Teen Information:

Name (last, first, middle initial) _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____ Phone _____

Email _____ Primary Provider _____

6. Child/Team Acknowledgement:

- I understand that CBHA's Patient Portal record disclosures covered under this proxy form **includes ALL records**, including information that as a minor, would otherwise be protected from (not disclosed to) my Parent/Legal Guardian without my consent according to Washington State Minor Consent and 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: _____