Southwestern Vermont Medical Center
Health Information Services
100 Hospital Drive, Box 49
Bennington, VT 05201
802-447-5687
802-440-4076 fax

Health Information Services
Patient Portal Proxy Authorization

Please complete this form if you are an adult patient at least 18 years of age and want to give another adult access or grant proxy access to your **patient portal account**. Also complete this form if you are a legal guardian or have a durable power of attorney for healthcare of an adult patient and you are requesting proxy access on behalf of that patient. You will be required to provide documentation to show you have legal right to proxy access. The patient portal account contains limited medical information. If you have questions, please contact the Health Information Department at 802-447-5687.

To request access, you must complete this patient portal proxy authorization and present to the provider's office or Health Information Department.

PATIENT INFORMATION: All information is required. *PLEASE PRINT CLEARLY*

Last name: ______________________ First name: ______________________

Date of birth: ______________________ Medical record number (if known): ______________________

Email address: ______________________

Street address: ______________________

City: ______________________ State: __________ Zip code: ______________________

Primary phone number: ______________________

PROXY INFORMATION: All information is required. *PLEASE PRINT CLEARLY*

Name of proxy (the person you are granting permission to access your patient portal account)

Last name: ______________________ First name: ______________________

Proxy's email address: ______________________

Proxy's street address: ______________________

Proxy's city: ______________________ State: __________ Zip code: ______________________

Primary phone number: ______________________ Proxy's date of birth: ______________________

REVOCATION OF PROXY AUTHORIZATION

I understand that I have a right to revoke this authorization at any time. It is my responsibility to revoke proxy access by deactivating the proxy account if I no longer wish this individual to access my information. I understand that the revocation will not apply to information that has already been released. Please send a written revocation to the Health Information Department. This authorization will remain in effect until revoked. Please mail or fax to the address on page 1.

PATIENT INITIALS __________

NOTICE

Southwestern Vermont Medical Center and other organizations and individuals, such as physicians, hospitals and health care plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it will no longer be protected by state and federal laws.

PATIENT INITIALS __________

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Patient Portal Proxy Authorization Continued

I understand that the information to be released may include information relating to the diagnosis and/or treatment of mental illness, alcohol/drug abuse, sexually transmitted infections including HIV or AIDS, test results, developmental disabilities and genetic testing results.

PATIENT INITIALS __________

Signature of patient and patient's legal representative or proxy:

Patient's printed name: ____________________ Patient's signature: ____________________ Date __________

Proxy/Legal representative's printed name: ____________________ Proxy/Legal representative's signature: ____________________ Date __________

Legal representative's relationship to the patient: ______________________________

FOR SVMC STAFF USE ONLY

☐ Photo ID Verfication

☐ Signature Verfication

Document Verification:

☐ Durable Power of Attorney for Healthcare

☐ Court Order

Attach copy of legal documentation and scan

☐ Scanned

Employee Signature: ______________________________ Date: __________

Portal:

☐ Medical Practice Practice Name: ____________________

☐ Hospital