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
Child Proxy Form

To sign up for access to your child's portal, please complete and sign this Child Proxy Form and return it to the address above.

☐ Access to Medical Practice ☐ Access to Hospital Portal

Birth or Adoptive Parent (Proxy): (Completion of all sections is required-please print clearly)

Last name: _____ First name, Middle initial: _____

Date of birth: _____ Primary phone number: _____

Email address: _____

Street address: _____

City: _____ State: _____ Zip code: _____

Please note the following age range limitations for the Portal. These age range limitations do not affect any legal right you have to access your child's record by other means. To request a copy of your child's record in paper or electronic format, contact the Health Information Department (Medical Records) at the address above.

- If your child is age **0-11:** You will be granted access to your child's portal.
- Once your child reaches **age 12**, access will automatically be deactivated.

The following information is needed for proxy access: All fields are required, A form must be provided for **each child.** If you need additional forms, request another proxy access form from the Health Information Department.

Child's last name: _____ First name, Middle initial: _____

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 need access to this 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 above.

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.

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.

Parent's Signature: _____ Date: _____

FOR SVMC STAFF USE ONLY

Attach copy and scan ☐ Scanned

Employee Signature: _____ Date: _____

Portal:
☐ Medical Practice Practice Name: _____
☐ Hospital