**Southwestern Vermont Medical Center**
**Health Information Services**
100 Hospital Drive
Bennington, VT 05201
802−447−5687 phone
802−447−5138 fax
ReleaseofInformation@svhealthcare.org

# 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 proxy access to **your medical record** through their 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 a legal right to proxy access. Patient portals do not contain the complete patient medical record. If you have questions, please contact the Health Information Services department at 802−447−5687

To permit or request access, you mut complete this patient portal proxy authorization and present it to your provider's office or SVMC Health Information Services by either mail, fax, or email.

*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 medical record through the patient portal)

Last name:_____ First Name:_____

Date of Birth:_____

Proxy email address: _____

Proxy street address: _____

City: _____ State: _____ Zip Code: _____

Primary phone number: _____

**REVOCATION OF PROXY AUTHORIZATION**

I understand that I have the right to revoke this authorization at any time. It is my responsibility to revoke proxy access by sending a written revocation to the SVMC Health Information Services department if I no longer wish this individual to have access to my medical record. This authorization will remain in effect until revoked.

**PATIENT INITIALS** _____

**NOTE**

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.

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I understand that the information viewable on the proxy's patient portal may include information relating to the diagnosis and/or treatment of mental illness, alcohol/drug use or addiction, sexually transmitted infections including HIV or AIDS, test results, developmental disabilities and genetic testing results.

**PATIENT INTIALS** _____

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

| Patient Name | Patient Signature | Date | Time |
|---|---|---|---|
| | | | |

| Proxy or Legal Representative Name | Proxy or Legal Representative Signature | Date | Time |
|---|---|---|---|
| | | | |

**FOR SVMC STAFF USE ONLY**

☐ Photo ID Verification ☐ Signature Verification

Document Verification **Attach copy of legal documentation and scan**

☐ Durable Power of Attorney for Healthcare ☐ Scanned

☐ Court Order

Employee Signature: _____ Date: _____ Time: _____

Portal:

☐ Medical Practice Practice Name: _____

☐ Hospital

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