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 Child Proxy Authorization

Complete this form to have **your child's medical record** added to your patient portal account. Return the form to the SVMC Health Information Services department by either mail, fax, or email. 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

Please note the following age range limitations for your child's medical record on 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 Health Information Services.

- If your child is age 0−11: You will be granted access to their medical record through your portal.
- Once your child reaches **age 12**: access will automatically be deactivated.

Requesting proxy access for: ☐ Hospital ☐ Medical Practice _____

Birth or Adoptive Parent (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: _____

The following information is required for child proxy access. All fields are required. A form must be completed for **each child.** If you need additional forms, you can print them off your portal, from the SVHealthcare website, or by contacting the SVMC Health Information Services department.

Child's last name:_____

First Name:_____ Date of Birth:_____

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 to have my child's medical record on my portal account. This authorization will remain in effect until revoked.

PARENT 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.

Information available through the patient portal my include information relating to the diagnosis and/or treatment of mental illness, alcohol/drug use or abuse, sexually transmitted infections including HIV or AIDS, test results, developmental disabilities and genetic testing results.

_____ _____ _____
Parent Signature Date Time

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FOR SVMC STAFF USE ONLY

Attach copy and scan ☐ Scanned

Employee Signature: _____ Date: _____ Time: _____

Portal:

☐ Medical Practice Practice Name: _____

☐ Hospital

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