

## Patient Portal Proxy Access Request Form For Incapable Adult & Minor Patients

**1. Patient Information:**

 Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  

Last
First
M.I.

 Address: \_\_\_\_\_  

Street Address
City, State
Zip
**2. Please check one of the boxes below that best describes the proxy access requested:** (Please note that for all types of proxy access, the patient's information will be accessed through the proxy's own patient portal account).

### Incapable Adult Patient

#### Access to an Incapable Adult's Patient Portal Record

**My relationship to the patient is:**

- Conservator of the person
- Durable Power of Attorney for Healthcare Decisions
- Health Care Representative
- Health Care Agent (New York State only)
- Other \_\_\_\_\_
- **Attach documentation verifying your ID, relationship and authority to have access to the patient's medical information.**
- **You must notify Nuvance Health in writing immediately in the case of any change in authority.**

### Minor Patient

#### Access to *Minor* Child's (age 0-11) Patient Portal Record

**My relationship to the Child is:**

- Parent of the Child
- Legal Guardian of the Child

If a legal guardian, attach a copy of the court order of legal guardianship. If parent has a different last name they must attach Paternity Acknowledgment or Birth Certificate.

You will be granted full access to your child's record until the child turns 12 years old. Between the ages of 12 - 18 no clinical information from their record will post to the portal account. At this age discussions between parents or guardians and the provider are best kept on a face to face or telephone basis.

**Proxy Information:**

By signing below, I the proxy acknowledge and agree that I will comply with the Patient Portal Terms and Conditions.

**X** \_\_\_\_\_  
 Signature of Proxy

 \_\_\_\_\_  
 Date

 Proxy Name: \_\_\_\_\_  

Last
First
M.I.

Date of Birth: \_\_\_\_\_

 Address: \_\_\_\_\_  

Street Address
City, State
Zip Code

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Questions Call: 203-739-7218**
**Send forms & documentation by Fax: 203-739-1542 or Email: [medicalrecords@wchn.org](mailto:medicalrecords@wchn.org)**