Proxy Access to Your Health Portal - Minor (12 - 17 years)

To sign up for access to your Health Portal record, please complete this form and return to a member of our registration staff or mail:
Boone County Hospital Health Information Management 1015 Union St. Boone, IA 50036.
ALL SECTIONS REQUIRED - PLEASE PRINT CLEARLY:

Patient Information:

Name: ______________________ ______________________ ________ Sex: ______
(Last Name) (First Name) (Middle Initial)

SSN: ________ / ________ / ________ Date of Birth: ________ / ________ / ________

Address: ______________________________ ____________________ ________ ________
Street: City: State: Zip:

Phone: (___)____________ (___) ____________ Email: ________________ @ ________________
Home Cell

Proxy Information:

Name: ______________________ ______________________ Sex: ______
(Last Name) (First Name) (Middle Initial)

Please Provide the Last 4 digits of SSN: ________ Date of Birth: ________ / ________ / ________

Address: ______________________________ ____________________ ________ ________
Street: City: State: Zip:

Phone: (___)____________ (___) ____________ Email: ________________ @ ________________
Home Cell

Does the Proxy Currently have a BCH Health Portal: ___
(A "Yes" indicates the Proxy requester already has a Health Portal Access.

Proxy Health Portal Terms and Conditions:

- I authorize release of any medical information (including any protected health information contained to the person named above as my proxy.
- I understand that my information is obtained from my electronic medical record and may include **Substance Abuse, Mental Health, HIV/AIDS/STDS/Other Infectious Disease and Genetic Information.**
- I authorization release of information only through Health Portal. This form does not authorized release of information in any other form.
- I understand that this is intended as a secure online source of confidential medical information. If I share my user id and password with another person, that person may be able to view this information.
- I understand that once information has been disclosed, it potentially may be re-disclosed by the proxy and may not be covered by federal privacy protections. I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if my password is compromised.
- I understand Health Portal contains select, limited medical information from a patient's medical record and does not reflect complete records. I understand that I may make a request for a copy of the record. I understand that access to Health Portal may be tracked by computer audit and entries I make may become part of the patient's medical record.
- I may revoke this authorization at any time by writing: Boone County Hospital, Health Information Management, 1015 Union St, Boone, IA 50036. I understand that such a revocation will not have any effect on any information already released to my proxy.
- I understand that the month prior to or during the month the patient turns 18 years of age, the proxy will be turned off.
- I understand that access is provided as a convenience and Boone County Hospital may deactivate access at any time for any reason. I understand that use of Health Portal is voluntary and I am not required to use.
- By signing below, I acknowledge that I have read and understand this form and acknowledge that I am proving proxy access to my information. Additional instructions and terms and conditions are available on the Health Portal.
- I may refuse to sign this authorization and understand that my refusal to sign will not affect my ability to obtain treatment. If I refuse to sign this authorization, access to my health portal account will not be granted.

Signature of Patient: ____ Date: ____________________

Proxy Signature: ______________________ Relationship to Patient: __________ Date: ____________________

Staff Use Only: Boone ___ Ogden ___ Madrid ___ CSC ___ Home Health ___Hospital ____ Initials___