Matthews-Vu
Healthcare for Children and Adults

PATIENT PORTAL PROXY (AUTHORIZED REPRESENTATIVE) SIGN-UP FORM

PATIENT INFORMATION		
Name:		Date of Birth:
Street Address:		Acct #:
City:		Phone number:
State:	Zip:	Email:

If you are requesting Proxy (Authorized Representative) access, please check one of the boxes below. Please note that, for all types of proxy access, the patient's chart will be accessed through a Proxy (Authorized Representative) patient portal account. Please note the following age range limitations for portal access as a Proxy (Authorized Representative). These age range limitations do not affect any legal right you have to access your child's record by other means.

☐ Adult-to-Child 0-12 years old (Access to your minor child's record)	If your child is age 0-12 years: You will be granted <u>full</u> access to your child's portal via a Proxy (Authorized Representative) account.
☐ Adult to 13-17 years old Child (access to your minor child's record) ☐ Full Access ☐ Restricted Access (vaccines and billing only)	If your child is age 13-17 years: Due to federal and state confidentiality laws, you may not access certain types of medical information without your child's consent (such as drug & alcohol, mental health, reproductive health and certain diseases). This is the law, this is not Matthews-Vu Medical Group policy. With your child's written consent, you may obtain portal access via a Proxy (Authorized Representative) account.
☐ Adult-to-Adult (Access to another adult's record) ☐ Full Access ☐ Restricted Access (vaccines and billing only)	The patient or patient's legal representative must sign this form to provide authorization for release of medical information in the form of a portal Proxy (Authorized Representative) account.
☐ Legal Representative (Documentation required)	☐ Legal Guardian (court order) ☐ Power of Attorney for Healthcare (documentation required) ☐ Other _____

PATIENT – I understand that:

- Use of the Patient Portal Proxy (Authorized Representative) is voluntary and I am not required to grant another person (proxy) access to my Patient Portal Account in this manner.
- By signing this document, I am acknowledging that I have read and understand the information above and I am granting this proxy to have access to my personal health information in the form of a Proxy (Authorized Representative) Portal Account.
- I may terminate this Proxy's (Authorized Representative's) access to my patient portal account at any time by contacting Matthews-Vu Medical Group unless there is a court order in place granting this Proxy (Authorized Representative) full access to my medical records.

PROXY (AUTHORIZED REPRESENTATIVE) – I understand that:

- This Proxy (Authorized Representative) access is intended as secure online access to this patient's personal health information. I may not share its login and password information with another person.
- I may use this Proxy (Authorized Representative) access to send messages about this patient; I may not use this patient's personal patient portal account (adult patients only).
- It is my responsibility to select a confidential password, to maintain this login name and password data in a secure manner and to change this password or contact Matthews-Vu Medical Group immediately if I believe it may have been compromised in any way. Access to the Matthews-Vu Medical Group Patient Portal is provided as a convenience to patients and their Proxy (Authorized Representatives). Matthews-Vu Medical Group has the right to revoke access to the Patient Portal by a patient or their Proxy (Authorized Representative) at any time for any reason.
- It is my responsibility to ensure that my e-mail address is current at all times. I understand that if my e-mail is not current, I will not receive notification of messages sent to me regarding this patient.

PROXY (AUTHORIZED REPRESENTATIVE) INFORMATION		
Name:		
Street Address:		Date of Birth:
City:		Phone number:
State:	Zip:	E-mail:

<u>PLEASE SEE NEXT PAGE</u>

By signing below, I acknowledge that I have read and understand this Patient Portal Proxy (Authorized Representative) Sign-Up Form and I agree to its terms. I choose to designate the person named above as my Proxy (Authorized Representative) thereby allowing them access to my medical record via my Matthews-Vu Medical Group Patient Portal Account.		
Name of Patient:	(Please Print)	
Signature of Patient:		Date:
Relationship to Patient:	☐ Parent ☐ Legal guardian ☐Power of Attorney ☐ Other: _____	
Signature of Authorized Representative:		Date: