Wray Hospital & Clinic

Authorization to Allow Proxy Portal Access

CHILD Proxy:

I am the parent/legal guardian of the child listed below. I request that Wray Community District Hospital and Clinic (WCDH) provide access to my child's account, allowing me to perform all functions offered within the Portal. I acknowledge and agree to the following:

- I understand that my child's personal, identifiable health information will be made available to me electronically thru that Portal.
- I understand that the use of the Portal is voluntary and intended for **non-emergent purposes only.**
- I understand that I will have the ability to view, download, and transmit the patient's information.
- **I understand that on the child's 14th birthday, proxy access to clinical data will end. At the age of 18, the patient may sign up for his/her own access and/or grant Proxy access as an adult.** (See below)
- I release WCDH, its employees and agents, medical staff, and business associates from legal responsibility or liability for my re-disclosure of Portal information.
- I understand that there are risks associated with web-based applications and that I am responsible for safeguarding access.
- I understand it is my responsibility to protect my username and password. I will not hold WCDH liable if I lose or share this information.
- I will receive an e-mail invitation to activate my access. I understand once I receive the invitation, if I don't log in within 90-days, I will need to complete a new request.
- I understand that my email address is required to initiate Portal access. If my e-mail address changes, or I wish to terminate access, I will contact WCDH at 970-332-2214.
- My signature represents that I have a legal right to this patient's health information.

Proxy's Name_____ Date of Birth_____

Patient Name_____ Date of Birth_____

_____ _____

Parent/Legal Guardian Signature Date Relationship to Patient/Authority

Email Address: _____

ADULT Proxy

I authorize the individual listed below (Proxy) to my protected health information and have access to all functions offered within the Portal. I acknowledge and agree to the following:

- This authorization is voluntary and made at my request.
- I have informed the Proxy that the use of the Portal is intended for **non-emergent purposes only.**
- I understand I am granting the Proxy ability to view my electronic health information, which may include records related to sexually transmitted and other communicable diseases like AIDS/HIV, Behavioral Health/Psychiatric care, alcohol and/or drug abuse, genetic testing etc.
- The Proxy will receive an e-mail invitation to activate the access. If he/she doesn't log in within 90-days, I will need to complete a new request.
- **I can revoke this authorization at any time by contacting WCDH at 970-332-2214. I understand that terminating access will not apply to information already been release in response to this access**

Proxy's Name_____ Date of Birth_____

Patient Name_____ Date of Birth_____

_____ _____

Signature of Patient/Authorized Representative Date Relationship to Patient/Authority