TELLURIDE REGIONAL MEDICAL CENTER

Request for CHILD (Age 0-11) Portal Proxy Access

Patient "Child" Information

Full Name_____Date of Birth _____

Email Address_____ Social Security Number: XXX-XX-_____(last 4 digits)

Address _____

City State Zip

Day Phone #_____Cell # _____

Proxy Information

Full Name_____ Date of Birth _____

Email Address_____ Social Security Number: XXX-XX-_____(last 4 digits)

Relationship to Patient_____ I have my own personal TRMC Patient Portal account: ☐ Yes ☐ No

Address _____

City State Zip

Day Phone #_____Cell # _____

Acknowledgement

- I understand that legal documentation (e.g. Guardianship or Legal Personal Representative) **may** be required. I must have parental rights or legal guardianship rights to access this child's record.
- I acknowledge that I have not been denied periods of physical placement with the child and there are no court orders or restraining orders in effect limiting my access to this child's medical records and/or information.
- I acknowledge that there are age range limitations for TRMC Patient Portal services. These age range limitations do not affect any legal right I have to access the child's record by other means. I can request a paper copy of the child's record by contacting TRMC.
- I understand that for a child age 0 to 11 years, I will be granted full access to the child's TRMC Patient Portal, and on the child's 12th birthday, I will have limited access to the child's TRMC Patient Portal unless the TRMC Teen Proxy Access Form is signed.
- I understand by submitting this form I, as the parent or legal guardian, have requested proxy access to the above-named patient's information that resides in the electronic health record portal (TRMC Patient Portal).
- I understand that the child's medical information is confidential. It is securely maintained in an electronic system by Telluride Regional Medical Center (TRMC).
- I understand that failure to comply with the TRMC Patient Portal User Agreement may result in the termination of portal access privileges.
- I understand that the child's TRMC Patient Portal **may** include a diagnosis or reference to the following condition(s): *behavioral health services/psychiatric care; reproductive health; sickle cell anemia; genetic testing; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); or drug and/or alcohol abuse.*
- I acknowledge if I cease to be responsible for the health care decisions of the child, I will notify TRMC immediately.
- I understand that TRMC reserves the right to revoke access to the TRMC Patient Portal at any time for any reason.
- I acknowledge that I have read and understand this Child (Age 0-11) Proxy Access form and that the full TRMC Patient Portal User Agreement is available to me online.
- I understand that this authorization for my access to the child's TRMC Patient Portal account will automatically expire: on the patient's 18th birthday, if TRMC receives notice and documentation that I am no longer the child's guardian, if TRMC receives notice and documentation that there is a court order or restraining order in effect that would limit my access to the child's medical records and/or information, when the child's TRMC Patient Portal account is deactivated, or when I revoke this authorization, whichever occurs first.

A signature is required to validate this request. By signing this form, the signer is requesting that the person(s) named above be granted access to electronically view the patient's medical record via the TRMC Patient Portal.

_____

Signature and PRINTED Name of Patient/Legal Representative (include relationship) Date

BRING PAPERWORK AND A FORM OF IDENTIFICATION IN PERSON TO:

Telluride Regional Medical Center
500 West Pacific Ave Telluride, CO

Office Use Only:

Proxy Photo ID verified:_____
Date received: _____
Date completed: _____