

Patient Information

Full Name _____ Date of Birth _____
 Email Address _____ Social Security Number: XXX-XX-_____ (last 4 digits)
 Address _____
 Day Phone # _____ Cell # _____ City _____ State _____ Zip _____

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 _____
 Day Phone # _____ Cell # _____ City _____ State _____ Zip _____

Acknowledgement

- I understand by submitting this form, I have requested the person indicated above to act on my behalf (a "proxy") to obtain information regarding my health included in my electronic health record.
- I understand that my 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 my 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 understand that information accessed may be subject to redisclosure by the Proxy and is no longer protected by the HIPAA Privacy rule.
- I understand that if proxy access to my TRMC Patient Portal is revoked, the information previously viewed by the above-named person(s) would not be considered a breach of confidentiality.
- 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 Teen (Age 12-17) Proxy Access form and that the full Terms and Conditions of the TRMC Patient Portal are available to me online. I agree to its terms and choose to designate the person named above as my Patient Portal Proxy, thereby allowing them access to my TRMC Patient Portal account.
- I understand that proxy access will be automatically terminated: on my 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 access to medical records and/or information, when the child's TRMC Patient Portal account is deactivated, or when I revoke this authorization, whichever occurs first, and that future portal access by proxy will have to be reestablished by completing a new proxy access authorization.

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 Date

Signature and PRINTED Name of Parent/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:
 Pt Photo ID verified: _____
 Date received: _____
 Date completed: _____