St. Peter's Health Patient Portal Proxy Registration Form

Once the patient has been registered for the St. Peter's Health Patient Portal, the proxy will receive an email from patientportal@sphealth.org with instructions to complete the account registration.

(Checked boxes indicate selection)

Patient Information:

Patient Name: _____ Date of Birth:_____
Last First Middle Initial

Address:_____ _____
Street Address City, State Zip Medical Record Number

E-mail Address:_____ Phone Number:_____

Proxy Information: (Person to whom you authorize St. Peter's Health to release the Patient Portal record to)

Proxy Name:_____ Date of Birth:_____
Last First Middle Initial

Address:_____ _____
Street Address City, State Zip Medical Record Number (if a patient)

E-mail Address:_____ Phone Number:_____

Does the proxy have an active Patient Portal Account? ❑ Yes ❑ No

Has the proxy ever been a patient at St. Peter's Health? ❑ Yes ❑ No

Please check one of the boxes that best describes the proxy access requested

(Please note that for all types of proxy access, the patient's chart will be accessed through the proxy's Patient Portal account)

Adult Patient (Note: This section also applies to Emancipated Minors. Emancipated Minors must provide proof of emancipation)

❑ **Adult-capable Adult Patient**

- The patient should sign this form to provide authorization for release of their medical information
- Authorization for proxy access is valid until revoked in writing by patient.

❑ **Legal Guardian of Adult Patient**
(Adults who have a surrogate relationship with another adult through a legal arrangement)

Check the option that best describes the Guardianship

❑ Legal Guardian (court order) ❑ Power of Attorney for Health Care ❑ Other:_____

- If you are the legal guardian or have a durable power of attorney for healthcare for this patient, a copy of the legal paperwork must be attached or already included in the patient's medical records.
- You must notify St. Peter's Health immediately in case of any change of authority.

Minor Patient (Note: Individuals requesting access must have parental rights or legal guardianship rights)

❑ **Parent**

❑ **Permanent Legal Guardian of the Patient** (Must attach or already have on file, a copy of the Court Order Appointing Guardian and Letters of Guardianship verifying the Proxy's status as permanent legal guardian of the patient)

YOU WILL BE GRANTED FULL ACCESS TO YOUR CHILD'S RECORD UNTIL THE CHILD TURNS 13 YEARS OLD.

(Continued on reverse side)

PATIENT IDENTIFICATION:

St. Peter's Health
2475 Broadway • Helena, MT 59601 (406) 442-2480

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Authorization:

- By signing this proxy request, I understand that I am giving my permission for St. Peter's Health to disclose my protected health information (PHI) through the Patient Portal to my Proxy. Information includes, but is not limited to: health summary, current problem list, current medications, lab results, appointment information, and provider/nurse messaging.
- The information available to my proxy may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, (2) treatment for drug or alcohol abuse, (3) sexually transmitted diseases, or (4) mental or behavioral health or psychiatric care.
- This proxy request includes records that were created or existing on or before the date this form was signed, as well as records that were created after the date this form is signed.
- I understand that I have the right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing. I understand that such a revocation will not have any effect on any information already released to my proxy.
- I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Montana State privacy laws.
- 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 Patient Portal account will not be granted.

By signing below, parents acknowledge and agree that:

- I will be using my own Patient Portal account at St. Peter's Health to access the child's account.
- I have parental rights or legal guardianship rights to access this child's account.
- 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.
- Communication on behalf of the child through the Patient Portal must be sent from the child's records and responses will be received in the child's record. Patient Portal e-mail alerts will be sent to the e-mail address entered under the Parent/Legal Guardian ("Proxy") Information.
- I will be granted full access to the child's Patient Portal record. On the child's 13th birthday, I will no longer have access to the child's record.

Legal Guardians:

Any documents, if any, I have provided in support of my right to access the patient's protected health information, are true and correct copies and are the most recent documents related to this matter. When my legal authority to act on behalf of the patient has been inactivated, revoked, terminated, or expired, I must immediately notify St. Peter's Health in writing of the change in authority and mail it to the Medical Records Department.

Patient/Parent: By signing below, I acknowledge and agree that:

- I will comply with the terms and conditions on the Patient Portal Terms and Conditions page and this document.

X_____ _____ _____

Patient, Parent or Legal Guardian Signature | Relationship to Patient | Date

Proxy: By signing below, I acknowledge and agree that:

- I will be using my own Patient Portal account to access the patient's Patient Portal account.
- I will comply with the terms and conditions on the Patient Portal Terms and Conditions page and this document.
- The patient can revoke my access to his/her Patient Portal account at any time.

X_____ _____ _____

Patient, Parent or Legal Guardian Signature | Relationship to Patient | Date

St. Peter's Health Employee Signature:_____Date:_____

St. Peter's Health Employee (print):_____

(Checked boxes indicate selection)

❑ I, the St. Peter's Health employee noted above, have verified identification of the above patient and/or proxy, by means of either a photo ID, or Palm Secure palm scanning.

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