Choosing Health
Northeastern Vermont Regional Hospital

NVRH PROXY ACCESS REQUEST & AUTHORIZATION FORM
Patient Portal Access -Adult Patient (18 or Older)

1. Patient Information

Patient Name	Date of Birth	MRN# *(if known)*
Patient Address		

2. Proxy Information: (Person to whom you authorize NVRH to release the Patient Portal record)

Proxy Name	Date of Birth	Relationship to Patient:
Address	Phone:	
Preferred Email Address for Portal Account (please print):	Confirm Email Address (please print):	
Does the proxy have an active NVRH Patient Portal account? ☐ Yes ☐ No		

3. Type of Proxy Access Requested (Select ONE)

☐ **Adult Patient Authorizing Proxy Access** (*The adult patient must complete and sign this section)*

Under the HIPAA Privacy Rule (45 CFR §164.508), an adult patient may authorize another individual to access their protected health information (PHI) through the Patient Portal.

☐ **Adult Patient – Legal Guardian or Health Care Agent**

The proxy is acting as a court-appointed guardian or health care agent under a valid Durable Power of Attorney for Health Care.

Documentation required (Attach One of the Following, as Applicable):
☐ Court-appointed Guardian (attach current court order)
☐ Durable Power of Attorney for Health Care (attach document demonstrating current authority)

Documentation must demonstrate current legal authority to make health care decisions on behalf of the adult patient.

The proxy must provide documentation demonstrating that such authority has not been revoked, terminated, or expired.

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4. Authorization

By signing this proxy request:

- I authorize NVRH to provide the designated proxy access to the patient's protected health information (PHI) through the Patient Portal.
- Portal access may include, but is not limited to: health summaries, problem lists, medications, laboratory results, appointment information, and secure messaging.
- The information accessible through the portal may include sensitive health information, such as information relating to HIV/AIDS, sexually transmitted infections, reproductive health services, substance use disorder treatment, and mental or behavioral health services. Access to certain information may be restricted in accordance with Vermont or federal law.
- This authorization applies to information currently maintained and information created in the future, unless revoked.
- I understand that I may revoke this authorization in writing at any time. Revocation will not affect information already accessed prior to revocation. Revocation requests must be submitted to NVRH Health Information Management.
- I understand that information accessed by a proxy may be subject to re-disclosure and may no longer be protected by federal or Vermont privacy laws.
- I understand that refusal to sign this authorization will not affect the patient's ability to receive treatment; however, proxy portal access will not be granted.

Adult Patient (Required if Adult Authorization Selected)

I authorize NVRH to grant proxy access as described above.

Patient Signature: ____________________________ Date: ____________________________

Legal Guardian / Health Care Agent for Adult (Required ONLY if Adult Guardian section selected)

I certify that I have legal authority to act on behalf of the adult patient and have attached required documentation. I further certify that there is no court order or legal limitation restricting my authority to access the patient's medical information.

Signature: ____________________________ Date: ____________________________

Relationship to Patient: ____________________________

Proxy Acknowledgment (Required in All Cases)

I agree to comply with portal terms and safeguard login credentials.

Proxy Signature: ____________________________ Date: ____________________________