



NVRH PROXY ACCESS REQUEST & AUTHORIZATION FORM
Patient Portal Access -Minor Patient Under Age 18

1. Patient Information

Form with fields: 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)

Form with fields: 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

Form containing checkboxes for 'Parent or Legal Guardian Requesting Access to Minor's Portal', 'I certify that I am the minor patient's:', 'I further certify:', and 'Important Notice Regarding Minor Confidentiality'.



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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.

Parent / Legal Guardian of Minor

I certify that I am the minor’s parent or legal guardian with authority under applicable law and that the statements above are accurate.

Signature: _____ Date: _____

Relationship to Minor: _____

Proxy Acknowledgment (Required in All Cases)

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

Proxy Signature: _____ Date: _____