CHI Mercy Health
Mercy Medical Center

2700 NW Stewart Pkwy
Roseburg, OR 97471
(541) 673-0611

Meditech Patient Portal - Child Proxy Request Form

(Proxy access for minors under the age 13)

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1. Child Patient Information:

Patient Name: _____ **Date of Birth**: _____
Last First M.I

Address: _____ **Medical Record Number:**_____
Street Address City, State Zip Code **(Optional)**

2. Proxy Information (Parent/Guardian):

Proxy Name: _____ **Date of Birth**: _____
Last First M.I

Address: _____ **Phone Number:** _____
Street Address City, State Zip Code

Email Address: _____

Does the proxy have an active Meditech Portal account? Yes ☐ No ☐

Has the proxy ever been a patient at one of our healthcare facilities? Yes ☐ No ☐

Minor Patient

Access to your minor child's Meditech Portal record.

- Individual requesting access must have parental rights or legal guardianship rights. **This will be full access to the child record.**

My Relationship to the Child is:

☐ Parent ☐ Permanent Legal Guardian of the Patient – Must attach a copy of the Court Order Appointing Guardian and Letters of Guardianship verifying the Proxy's status as permanent legal guardian of the patient.

By signing below, parents acknowledge and agree that:

• I have parental rights or legal guardianship rights to access this Child's record.
• 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.
• For a child aged 0 to 12 years, I will be granted full access to the Child's Meditech Portal record. On the Child's 13th birthday, I will no longer have access to the Child's Meditech Portal record unless the child authorizes me to access any specially protected information - mental health, reproductive services, HIV and AIDS and chemical dependency.

Legal Guardians:

I confirm that any documents 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 the healthcare facility in writing of the change in authority and mail it to the Health Information Management Department.

X_____ _____
Parent or Legal Guardian Signature (Required) Date (Required)

For HIM Department Use Only:	Date Granted_____	User's initials_____