Hill Physicians

Proxy Access Authorization Form

Proxy access lets parents and legal representatives manage the care of another via our patient portal, **MyHill*Chart***. A proxy can access a patient's medical records and health information listed below. You may cancel this authorization at any time by contacting Customer Service.

What information can a Proxy see?

Patient aged 0–11, full medical record:

- Labs
- Immunization records
- Allergy records
- Growth charts
- Message care team
- Appointment requests
- Appointment view
- Problem list / summary
- Medication refill requests

Patient aged 12+, limited medical record (not full):*

- Immunization records
- Allergy records
- Message care team
- Appointment requests

* Note: If the patient has diminished capacity, you may be able to access the full medical record under certain circumstances. Contact Customer Service for details.

Section 1 – Patient Information

First Name _____ Last Name _____

Date of Birth _____ /_____ /_____ Health Plan ID (found on the medical card) _____

Patient's Age Group: ◯ Ages 0–11 ◯ Ages 12+

Are you the patient's parent?

◯ Yes ◯ No

If No, explain your legal authority to act for the patient and provide documentation of your authority.

_____

_____

_____

Section 2 – Requestor (Proxy / Person Getting Access) Information

First Name _____ Last Name _____

Date of Birth _____ /_____ /_____ Phone Number (_____) _____ ◯ Mobile ◯ Home ◯ Work

Email Address _____

Street Address _____ City _____ State _____ Zip _____

–Form continued on next page

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Section 3 – Authorization and Signature

Please Note: When submitting this form, you are required to **include a photo of a valid government-issued ID** *(e.g., driver's license, passport, or state ID).*

By signing below, I confirm that the information on this form is true and complete. I am the person requesting proxy access and I am legally allowed to request this access. I authorize the release of the patient's medical records and health information to me through proxy access, as permitted by federal and state law. I understand that my access is limited to the information described above and will end on the patient's 18th birthday, unless I have legal authority to act on the patient's behalf beyond that date.

Signature of Requestor/Proxy _____ Date _____ /_____ /_____

Printed Name _____

Please submit this completed form and a copy of a valid government-issued ID (e.g., driver's license, passport, or state ID) to:

Mail: Hill Physicians Medical Group, Attn: Customer Service, P.O. Box 5080, San Ramon, CA 94583

Fax: (925) 327-6626, Attn: Customer Service

Email:* customerservice@hpmg.com

* Messages sent by email may not be secure. If you choose to return this form via email, you accept the risk that a third party may intercept the message and view your form.

For Customer Service: Date received: ____/____/____ Processed by: _____ ID confirmed: ◯ Yes ◯ No

