



This form lets you choose a person (a “proxy”) who can see the patient’s medical records and health information listed below. Filling out this form is optional. However, we cannot give access unless the form is complete and signed. This authorization follows applicable federal and state privacy laws, including HIPAA. You may cancel this authorization at any time by submitting a written request to the Hill Physicians’ Customer Service Department.

### A Proxy Can See:

*(limited access not full medical record)*

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

## Section 1 – Patient Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

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

Do you have legal authority to act for the patient? (i.e. parent, legal guardian, court order, or power of attorney.)

Yes  No

If No, explain your relationship and legal authority: \_\_\_\_\_  
*We may ask for proof (i.e. a court order or power of attorney).*

## 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 \_\_\_\_\_

**Full Access Eligibility:** Sometimes, a parent or legal guardian can get full access to a patient’s account ages 12-17. This may apply if the patient has a medical condition that makes it hard to make their own health care decisions.

**Please check this box if your child has a condition that affects their ability to make independent medical decisions.** *If you checked this box, a Customer Service representative will contact you to review eligibility and explain full access options.*

## 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, to the best of my knowledge, the information on this form is true and complete. I am the person requesting proxy access, and I am legally authorized to do so. 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.

Requestor/Proxy Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Printed Name \_\_\_\_\_

For Customer Service: Date received: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Processed by: \_\_\_\_\_ ID confirmed:  Yes  No