BUTLER MEMORIAL HOSPITAL

My BHS Health Proxy Access: Power of Attorney/Legal Guardian Proxy Request Form- Adult Patient (For patients under 13 years of age)

Note: There will be one Agreement signed by each Parent/Legal Guardian

Minor Patient Information:

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

Address: _____ **Phone:** _____

Medical Record Number: _____ **Last Four Digits of Social Security Number**: _____
(Optional)

I am the parent or legal guardian for the child named above. I am requesting access to My BHS Health Record for viewing the above child's records over the internet. Information included in My BHS Health Record includes, but is not limited to: health summary, current problem list, current medications, lab results, appointment information and diagnostic/testing information.

These records may also contain information related to: (1) acquired immune deficiency syndrome (AIDS) or human immune deficiency virus (HIV); (2) treatment for drug and alcohol abuse; (3) sexually transmitted diseases, contraceptive use, or birth control; and (4) mental or behavior health treatment, as well as medication prescribed that relate to these conditions.

I understand that when the above patient turns 13 years of age, my ability to access My BHS Health Record will stop.

By signing this proxy request, I am confirming that I am the parent or legal guardian for the child and that I have not had my parental rights terminated. I am confirming that I am not otherwise restricted to the child's medical information.

_____
Print name of parent/guardian

_____ **Date:** _____
Signature of parent/guardian

Email Address: _____

Relationship to the Patient:_____

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