

**Authorization for Proxy Access to Patient Portal  
DCH Health System**

**Patient Information** (please print)

\_\_\_\_\_  
Patient Name Phone Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
Medical Record # Date of Birth

I authorize the following individual to participate in DCH Health System's Patient Portal as my proxy.

**Proxy Information** (please print)

\_\_\_\_\_  
\*Proxy Name Relationship to patient

\_\_\_\_\_  
\*Proxy Email Address

I understand that my proxy will have the same access and privileges that I have for the Patient Portal. I understand that this allows my proxy online access to my personal health information. My proxy will be able to view portions of my record that I am able to view. I also understand that additional information may be made available to my proxy through the patient portal as DCH Health System continues to implement this product..

By signing this authorization, I am requesting DCH Health System to give access to my proxy to utilize the patient portal. I understand the DCH Health System will require my proxy to sign an acknowledgment and agree to DCH Health System's policies and procedures for use of the patient portal.

This authorization is valid until revoked by me. I understand that a written request is necessary to revoke or cancel this authorization. However, I understand that my revocation will not be effective as to uses and/or disclosures already made in reliance upon this authorization. I realize that the information used and/or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy laws.

**Patient Acknowledgement**

\_\_\_\_\_  
Signature of Patient Date/Time

\_\_\_\_\_  
Signature of Legal Representative Date/Time Relationship to patient



**Authorization for Proxy Access  
to Patient Portal**



**My-DCH Patient Portal Access**  
**Instruction and Documents needed to access My-DCH**

<b>Access to Patient Portal</b>	
<b>Adults 14-and above</b>	Complete DCH Enrollment Request with one of the following.
	Valid Government Issued Picture ID.
	<b>If no valid picture ID:</b>
	Birth Certificate and Social Security Card.

**PROXY: Gives another person access to review or print a patient's medical record from the MyDCH patient portal.**

<b>Proxy to Patient Portal</b>	
<b>Children 0-13</b>	Complete DCH Proxy Request with Valid Government Issued Picture ID for person being granted proxy and the following for the patient.
	Birth Certificate or Guardianship papers
<b>Adults 14-and above</b>	Complete DCH Proxy Request with Valid Government Issued Picture ID for person being granted proxy and one of the following for the patient.
	Valid Government issued Picture ID.
	<b>If no valid pictured ID:</b>
	Birth Certificate and Social Security Card.
<b>Patient unable to sign proxy</b>	Complete DCH Proxy Request with Government Issued Pictured ID for person being granted proxy and one of the following for the patient.
	Medical Power of Attorney
	Guardianship papers.



**Request for MyDCH Access**

