

# Samaritan Regional Health System Patient Portal Proxy Access Application

(Provides Parent/Legal Guardian access to the electronic record of a minor)  
(Provides designated adult access to the electronic record of a patient)

Please provide the last four digits of the Social Security Number or another unique four digit number for each proxy access request. This number will allow access to their medical record via your patient portal. \_\_\_\_\_

## To Request Proxy Access - Minor Child

Child's name \_\_\_\_\_ Date of birth \_\_\_\_\_ Gender \_\_\_\_\_

Parent/Legal Guardian name \_\_\_\_\_ Date of birth \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Phone number \_\_\_\_\_  
(Legal documentation is required)

Second Parent/Legal Guardian name \_\_\_\_\_ Date of birth \_\_\_\_\_  
(If applicable)

Relationship to patient \_\_\_\_\_ Phone number \_\_\_\_\_  
(Legal documentation is required)

Email address unique to proxy \_\_\_\_\_  
(Please print legibly)

**NOTE: Please provide a unique email. If email address is shared with another individual who also has a patient portal, each will have access to the other's portal information.**

## To Request Proxy Access - Adult

Patient name \_\_\_\_\_ Date of birth \_\_\_\_\_

Proxy name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Email address unique to proxy \_\_\_\_\_  
(Please print legibly)

**NOTE: Please provide a unique email. If email address is shared with another individual who also has a patient portal, each will have access to the other's portal information.**

By signing below I confirm that I have read, understand, and agree to comply with the procedures and guidelines for using the Samaritan Patient Portal.

Signature \_\_\_\_\_ Date \_\_\_\_\_