

# My eHealth

## Proxy Request Form

You can use this form to request access to view another person's medical record via My eHealth. You will need to obtain the proper information, including a signature granting access, from the patient.

### PART A: Enter your information below.

Last Name, First Name, Middle Initial			Date of Birth
Address	City	State	Zip
Email Address		Phone	

**PART B: Please list below the patient whose information you are requesting. You will need to complete all of the information below, including the patient's signature. We will review all of this information and we may contact the patient to confirm permission. The patient may revoke proxy access at any time.**

Patient Name		Date of Birth
Relation to Proxy*	Date	Patient Signature (Legal Guardian)

By signing above, I authorize the above named person to review portions of my electronic medical records maintained by Watertown Regional Medical Center (WRMC) on the My eHealth portal.

### Understandings & Agreements of Patient

1. I acknowledge that authorization is voluntary.
2. I understand that I may revoke this authorization at any time by notifying the facility in writing, but if I do, it will not have any effect on any actions taken prior to the facility's receipt of the revocation.
3. I agree to waive all claims against the facility for the release of the requested information in accordance with my authorization.
4. I understand that Watertown Regional Medical Center cannot condition admission to the facility upon my providing this authorization.

\*Proxy access to a child's record will automatically be terminated at age 13.

\* To reinstate access, the parent/guardian must obtain a new proxy request with the child's authorization. This access will automatically terminate at age 18.