

Online Health Record Proxy

The FollowMyHealth™ patient portal at Sea Mar Community Health Centers is designed to enhance secure patient and provider communications and is provided as a courtesy to our valued patients. Please complete and submit this form along with copies of required legal documents to authorize Sea Mar to email an invitation to create a portal account.

Purpose for Access:	PERSONAL ACCOUNT ACCESS: (photo ID required)
	<input type="checkbox"/> I am 13-17 years of age and grant Read Only Access to my medical records to the representative (proxy) listed below
	<input type="checkbox"/> I am 13-17 years of age and grant Full Access to my medical records to the representative (proxy) listed below
	<input type="checkbox"/> I am 18 years or older and grant Read Only Access to my medical records to the representative (proxy) listed below
	<input type="checkbox"/> I am 18 years or older and grant Full Access to my medical records to the representative (proxy) listed below
	PROXY (representative of patient) ACCOUNT ACCESS:
	<input type="checkbox"/> I have legal paperwork for POA/Guardian/Adoption/Ward of the State or County for this patient listed below (copies of legal documents and photo ID required)
	<input type="checkbox"/> Full Access to a patient medical record <i>(indicate legal status below)</i> <input type="checkbox"/> Read Only Access to a medical record <i>(indicate legal status below)</i>
<input type="checkbox"/> I am the parent of a Minor patient aged 12 or younger listed below (ID required)	
<input type="checkbox"/> Full Access to a patient medical record <i>(indicate legal status below)</i> <input type="checkbox"/> [Staff Only: Confirm relationship in PM]	

Patient Information *(please print):*

Patient Name: _____
 FIRST NAME MIDDLE NAME LAST NAME

Patient DOB: _____ Phone: _____
 MM/DD/YYYY

Email address where patient portal messages will be sent: _____
(PERSONAL EMAIL RECOMMENDED)

I hereby authorize Sea Mar Community Health Centers to use/disclose individually identifiable health information to the FollowMyHealth™ patient portal for my online access to Sea Mar health care information:

Patient Signature: _____ Date: _____

Proxy Access (Patient representative): *(please print):* (Representative receiving access to a Patient Portal account)

Proxy Name: _____ FIRST NAME MIDDLE NAME LAST NAME
Proxy DOB: _____ Relationship to Patient: _____ MM/DD/YYYY
Email address where PROXY portal messages will be sent: _____ <i>(PERSONAL EMAIL RECOMMENDED)</i>
Address: _____ STREET ADDRESS CITY, STATE ZIPCODE
Home phone: _____ Cell phone: _____
Proxy Signature: _____ Date: _____
I hereby authorize Sea Mar Community Health Centers to use/disclose individually identifiable health information with the representative (proxy) listed above:
Patient signature (if required): _____ Date: _____

Staff only

<input type="checkbox"/> Reviewed by: _____	<input type="checkbox"/> Proxy invite sent
<input type="checkbox"/> Proxy access approved	Supporting documentation: _____
<input type="checkbox"/> Proxy access denied	Reason denied: _____