Baystate Health

myBaystateHealth
Patient Portal Proxy
Authorization Form

Baystate Health is making it easier for you or your health care proxy to communicate with Providers, review test results, and maintain personal health records through its electronic patient portal called myBaystateHealth. This **Patient Portal Proxy Authorization** is for:

- **A patient** who wants to permit another person, such as a spouse or an adult child, to access their myBaystateHealth patient portal account.

- **A parent or guardian of a minor** child (under the age of 13) to request access to their minor child's myBaystateHealth patient portal account. The child's parent or guardian does not have to be a Baystate patient in order to request proxy access for the child on the myBaystateHealth patient portal. ***Portal access is not available for children ages 13 through 17.***

- **An authorized representative of an adult patient**, such as a legal guardian or other legally authorized representative who makes health care decisions on a patient's behalf, to request access to a patient's myBaystateHealth patient portal.

Proxy access is only granted for one year and will automatically expire. This process will need to be repeated yearly for ongoing patient portal proxy access.

To request patient portal proxy access, please **submit this completed authorization form** (and any supporting documentation) to the Baystate Health Information Management Department (HIM) in one of the following ways:

1. Fax the documents to 413.322.4346.
2. Scan and email the documents to portalproxy@baystatehealth.org.
3. Mail the documents to the HIM department at: 361 Whitney Ave, Holyoke MA 01040 and write "Attention Correspondence Dept" on the envelope.
4. Drop-off the documents at the HIM department: 759 Chestnut Street, Springfield MA 01199 (Open 9-5 Mon-Fri) or 361 Whitney Ave, Holyoke MA 01040 (Open 24/7).

Please note: You will be notified by email when the HIM department approves your myBaystateHealth patient portal proxy request.

If you have additional questions, please call the HIM department: 413.322.4357.

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PATIENT'S INFORMATION

Patient's Name (print): _____

Date of Birth: ____/____/_____ Gender:_____ Phone Number:_____

Address: _____ City, State, Zip: _____

I authorize Baystate Health to release all information in the myBaystateHealth patient portal to the proxy listed below. I am signing this Authorization voluntarily, and these records are released at my request. I understand that I have the right to revoke this authorization by contacting the HIM department. I understand that once disclosed, the information in my portal may be redisclosed by my proxy and is no longer protected by state or federal privacy laws.

Signature of Patient or Authorized Representative: _____
Date: ___/____/____

If signing as an Authorized Representative of the Patient, you certify that you are the (check one):
☐ Parent ☐ Legal Guardian* ☐ Healthcare Proxy (for a patient determined to be incapacitated)*
☐ Power of Attorney (for health care matters)* ☐ Executor of Estate of Deceased Patient*
Proof of relationship may be required.

PROXY'S INFORMATION
(A PROXY IS THE PERSON, OTHER THAN PATIENT, REQUESTING ACCESS TO THE PORTAL)

Proxy's Name (print): _____

Date of Birth: _____/_____/_____Maiden Name of Proxy's Mother: _____

Proxy's Email (required, print clearly)_____@_____

Address: _____

City: _____State: _____ Zip code:_____ Phone:_____

For HIM Office Use Only - Please Do Not Write Below This Line

HIM Staff:

Type of Proxy (check one):
☐ Parent ☐ Legal Guardian ☐ Healthcare Proxy (for a patient determined to be incapacitated)
☐ Power of Attorney (for health care matters) ☐ Executor of Estate of Deceased Patient

Proxy Relationship Verified: Yes_____ No_____ Initials:_____
Record Reviewed: Yes_____ No_____ Initials: _____
Patient Portal Access completed: Yes_____ No_____ Initials: _____