Portal Proxy Request Form

A. PATIENT INFORMATION:

Patient Name (please print): _____

Date of Birth: _____ SS# (optional): _____

Other names: _____

Email address:_____ Phone #:_____

B. ABOUT THE HEALTH INFORMATION:

I am requesting an official invite to the Cottage Health system patient portal that will allow me to access confidential health information that is included as part of my medical record or as part of the medical record for a patient for which I am the legal guardian or representative.

AUTHORIZING SIGNATURE: (Electronic signature not valid)

Signature: _____ Date: _____

Print Name: _____ 4 Digit Year of Birth: _____

If not signed by the patient, please indicate relationship. Legal proof validating authority will be required before this request can be honored:

☐ Parent or guardian of minor patient up to 12 years of age.

☐ Guardian or conservator of an incompetent patient.

Note: Proxy accounts will be removed once the minor patient turns 12 years old.

VALIDATION SECTION FOR CHS STAFF USE:

Date/Time Received:	MRN/Encounter:
Received by (staff initials):	Verification document:
Requestor ID verified by (staff initials):	Verification document(s):
Non patient - Authority to access verified by (staff initials):	
Invite submitted on:	

Cottage Health

GOLETA VALLEY | SANTA BARBARA | SANTA YNEZ VALLEY