

**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)

**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)

**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.**

**To Revoke Proxy Access - Adult**

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

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

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

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 \_\_\_\_\_