Stormont Vail Health

Cotton O'Neil

Please Mail Form to:
Stormont Vail Health
MyChart Proxy Access
1500 S.W. 10th Ave., Topeka, KS 66604

Special Contact Instructions and Proxy Designation Form - Minor Patients 0-14

Step 1

Patient Name_____

Street Address_____ City_____ State_____ Zip_____

Date of Birth_____ Physician_____ MRN_____ (Office use only)

I hereby authorize **Stormont Vail Health / Cotton O'Neil** and designees to discuss the care and treatment, arrangements for care and treatment, or payment for care and treatment with the following individuals listed below who are involved with my care for the duration listed below. I understand that the provider may require a more specific release for certain information.

This permission is effective for a period of: ☐ One Month ☐ Until Age 15

Only for the test or procedure specified_____

In addition, by checking the MyChart® box for each individual listed, I hereby authorize Stormont Vail Health / Cotton O'Neil and designees to allow access to MyChart® for the following individuals who are involved with my care, in accordance with the Stormont Vail MyChart® Activation and Termination Policy. I understand that MyChart® proxy access will continue until I notify Stormont Vail Health / Cotton O'Neil of any changes to this list.

Please print when filling out form. All information is required.

Step 2

Via MyChart®	Via Phone	Who Can Access My Information: Name and Address	Date of Birth	Phone Number (with Area Code)	Relationship (No Abbreviations)
☐	☐				
Email:					
☐	☐				
Email:					

Step 3

I understand that I am responsible to notify Stormont Vail Health/Cotton O'Neil in writing to revoke or modify this request. Stormont Vail Health/Cotton O'Neil will make reasonable efforts to comply with this request. This form will supersede all prior requests unless otherwise indicated.

Parent/Representative

Signature (required)_____ Date_____Time_____

***NOTE:** If signed by a parent or personal representative, documentation regarding the person's legal authority must be verified and placed in the chart, *e.g.* Letters of Guardianship; Durable Power of Attorney for Health Care. Print the person's name and note the relationship to patient here:

(Print Name)_____ (Relationship)_____

Staff Verification_____ Dept. _____ Date_____

Patient Name_____ Date of Birth _____

Special Contact Instructions and Proxy Designation Form - Continued

Please print when filling out form. All information is required.

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