myCSVFolder PERMISSION FORM -ADULT PATIENT or CHILD AGE 0 to 13

Permission Form for *myCSVFolder for Adult Patient or Child Age 0-13:*

NOTE: Please print legibly

Patient Name:	**Birth Date:**

Full Mailing Address:

Email Address unique to Patient:

NOTE: If this is a shared email address, then all persons sharing it will have access to this patient's health Information.

To Grant Proxy Access (Required for Child Age 0-13, Optional for Adult Patient)

NOTE: Please print legibly

Name of Proxy: (For Child Age 0-13, must be Parent or Legal Guardian)	**Relationship to Patient**: _____ **Parent** _____ **Legal Guardian••** _____ Other (specify)_____ ** This request must be accompanied by a copy of legal paperwork verifying the individual's status as Legal Guardian.

Email Address unique to Proxy:

NOTE: If this is a shared email address, then all persons sharing it will have access to this patient's health information.

NOTE: Please print legibly

Patient Name:	**Birth Date:**

Patient Email Address:

Proxy Name to be removed:	**Relationship to Patient**: _____ **Parent** _____ **Legal Guardian**** _____ **Other** (specify)_____ ** This request must be accompanied by a copy of legal paperwork verifying the individual's status as Legal Guardian.

Proxy Email Address to be removed:

By signing below I confirm that I have read, understand, and agree to comply with the procedures and guidelines for using the Patient Portal.

Signature of Adult Patient or Parent/Legal Guardian of Child 0 to 13: (Required)	Date Signed (Required) (M/D/Y)

***Do Not use this form to request access for a child age 0-13 through myCSVFolder Patient Portal.

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CHRISTUS ST. VINCENT Regional Medical Center
Santa Fe, New Mexico
my CSV Permission Form
245885 (02/14)

PATIENT INFORMATION

Name _____
Date of Birth _____ Date of Service _____
Medical Record No. _____
Account No. _____