Gillette Children's
Specialty Healthcare

MyGillette Proxy Access Request

A proxy authorization means that you give another person full access to your Gillette medical record through an online Gillette Portal account. It is as if they were you. This might be a parent, or guardian, who helps you take care of your health. To create Proxy Access, the entire form must be completed.

Patient's Information – *whose patient record will be shared?*

First Name	Middle Name	Last Name
Address		City
State	Zip Code	Daytime Phone Number
Date of Birth	Gender M F	Medical Record Number

Proxy's Information – *who can access the patient's record?*

First Name	Middle Name	Last Name
Address		City
State	Zip Code	Daytime Phone Number
Date of Birth	Gender M F	Relationship to Patient
Proxy's Email Address	last 4 digits of the proxy's social security number _____ (this is for the Challenge Question-you will be prompted to change this when logging in the first time)	

By signing this form, I understand that:

1. I am authorizing Gillette Children's Specialty Healthcare to disclose (give out) my information to this proxy.
2. This authorization relates only to Gillette Children's Specialty Healthcare MyGillette Patient Portal.
3. All information accessible through MyGillette Patient Portal will become accessible to this proxy.
4. This authorization expires (ends) 5 years from the date access is granted.
5. **For minors 13 to 17 years old, this authorization MUST be filled out by the patient for parents/Legal Decision makers to have proxy to the patient portal.**
6. For minors 13 to 17 years old, this authorization expires when the patient turns 18 years old.
7. This authorization may be revoked at any time by notifying, in writing, the address listed above.
8. Revoking this authorization does not apply to information already released under this authorization.
9. Federal privacy laws protect information disclosed to a covered healthcare provider of health plan.
10. Information disclosed to other persons or entities may not be protected and may be re-disclosed.
11. I do not have to sign this form. Treatment will still be provided to me if I do not sign this form.

SIGNATURE AND ACKNOWLEDGEMENT

☐**Patient is unable to consent. List reason:** _____

_____ _____

Patient ***(if 13 and older)***/Parent/Legal Decision Maker Signature | Print Patient ***(if 13 and older)***/Parent/Legal Decision Maker Name

_____ _____

Relationship to Patient | Date

Telephone/Verbal consent obtained by (Name, Date, Title):_____

Legal decision maker authorization is required, in addition to the minor patient (age 13-17), when proxy access is granted to someone other than the legal decision maker.

_____ _____ _____

Parent/Legal Decision Maker Signature | Print Parent/Legal Decision Maker Name | Date

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Send completed and signed form by mail, fax or email to

Gillette Childrens
HIS-mailstop 205515
200 University Ave E.
St. Paul, MN 55101

Fax to 651-726-2605

MyGillette@gillettechildrens.com

Questions call: 651-229-3886

Please allow up to 10 business days for processing.
The proxy will receive an email containing a link to complete the enrollment process.

Internal Use Only
Date received: _____ Staff Name processing: _____

ID verified: Y N Email sent to Proxy (date) _____