CENTRAL MONTANA MEDICAL CENTER

PatientConnect Portal Proxy Authorization

Please complete this form if you are a parent or legal guardian of a minor patient, age 13-17, or if you are an adult patient and are requesting proxy access by another adult. Also complete this form if you are a legal guardian or have a durable power of attorney for healthcare, of an adult patient and you are requesting access on behalf of the that patient. You will be required to provide documentation to show you have legal rights to request this proxy access for adult patients.

Patient Information:

Last Name:______________________________First Name:____

Date of Birth:____________________________Patient Email Address:________________________________

Proxy Information:
Person you are granting permission to access your patient portal account

Last Name:______________________________First Name:____

Date of Birth:____________________________Email Address:____

Street Address:____City:_______________________

State:_______________Zip Code:_________________________Phone:_________________________________

Relationship to Patient

☐ Mother ☐ Father ☐ Legal Guardian ☐ Other:__________________

Security Questions (answer just one):

Last four digits of you SSN:_____________________________

Year you got married:___________________________________

Year you graduated high school:________________________

Year your father was born:______________________________

Year your mother graduated high school:_______________

Year your mother was born:_____________________________

Your postal code:_______________________________________

Patient Signature:____Date:_______________________

Proxy Signature:____Date:_______________________