Billings Clinic

Patient 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 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 (Please Print):

Last Name: _____ First Name: _____

Date of Birth: _____ Patient Email Address:_____

Proxy Information (Please Print): (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: _____

Telephone: _____

Relationship to Patient:

☐ Mother ☐ Father ☐Legal Guardian ☐Other_____

Security Questions (answer just one):

Last four digits of your 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 (If over 18) Date

_____ _____

Proxy Signature Date