Hazel Hawkins
MEMORIAL HOSPITAL

PROXY ACCESS PATIENT PORTAL

Please list the minors under the age of 12 that you would like to have access to their medical information. Be sure to supply the name and birthdate of each minor that you are requesting access.

Name _____ DOB ____/____/_____ AGE _____ SEX _____

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Name _____ DOB ____/____/_____ AGE _____ SEX _____

Name _____ DOB ____/____/_____ AGE _____ SEX _____

Name _____ DOB ____/____/_____ AGE _____ SEX _____

Please be sure to supply proof of relationship for minors. Please supply your valid ID as the parent or guardian of the minor.

Sign _____ Date _____