



## HEALTHCONNECT PATIENT PORTAL FAMILY ACCOUNTS

We can create Family Accounts by enrolling a parent, guardian or spouse as a Portal User, then attaching the children/spouse/senior parents to that account, provided we have a portal proxy form on file. PLEASE COMPLETE A SEPARATE PROXY FORM FOR EACH FAMILY MEMBER YOU WANT TO BE CONNECTED TO YOUR PORTAL. IF THE CHILD IS 12 YEARS OLD OR OLDER, THEY MUST SIGN THE FORM AS THE PATIENT.

**You may return the completed form by scanning and emailing it to [healthconnect@hancockregional.org](mailto:healthconnect@hancockregional.org). You may also mail the form to Hancock Physician Network, HealthConnect Patient Portal, Attn: Patricia, P.O. Box 129, Greenfield, IN 46140 or fax it to 317-468-6267. You may also return the form to Hancock Regional Hospital or any Hancock Physician Network office.**

You should know that once your children reach the age of 14 they will be removed from your portal account in accordance with Indiana state law. However, if the child signs a new portal proxy form we can add them back to the parent's account until the child reaches the age of 18 and/or becomes emancipated.

If you have not already been enrolled in HealthConnect, we would be happy to create a portal account by manually enrolling you in the portal, and when the proxy form is returned we can add your child/spouse/senior parent to your account. In order to create a portal, you had to have a visit somewhere through the Hancock Health system. If you wish to be enrolled at this time, please complete an enrollment form at Hancock Regional Hospital or any Hancock Physician Network office. You can also contact the HealthConnect patient portal team via email at [healthconnect@hancockregional.org](mailto:healthconnect@hancockregional.org) or call the HealthConnect Help Line at 317-468-6060. You should receive a welcome email within two business days with instructions on completing the enrollment process.

Your Hancock Physician Network provider is requesting for you to send a message to them through your portal. From your Home page, please click Messages, click Send Message and send a message to your Primary Care Provider. You can type something simple such as, "I am now enrolled on the patient portal!"

If you have any questions or concerns, please feel free to contact us via email at [healthconnect@hancockregional.org](mailto:healthconnect@hancockregional.org) or call the HealthConnect Help Line at 317-468-6060.



**Authorization for Proxy Access to Patient Portal - HealthConnect  
Hancock Regional Hospital**

**Patient Name: (Please print.)**

_____	_____	_____
First Name	Middle Initial	Last Name

Date of Birth: \_\_\_\_\_ Relationship to Portal User: \_\_\_\_\_

Address: \_\_\_\_\_

I authorize the below individual to participate in Hancock Regional Hospital's HealthConnect Patient Portal as my proxy.

**Portal User Name: (Please print.)**

_____	_____	_____
First Name	Middle Initial	Last Name

Date of Birth: \_\_\_\_\_

Email Address: \_\_\_\_\_

(Please supply the name and email address of the person who will be using the patient portal on my behalf)

I understand that my proxy will have the same access and privileges that I have for the Patient Portal if applicable. I understand that this allows my proxy online access to my personal health information. My proxy will be able to view portions of my record that I am able to view. I also understand that additional information may be made available to my proxy through the patient portal as Hancock Regional Hospital continues to implement this product.

By signing this authorization, I am requesting Hancock Regional Hospital to give access to my proxy to utilize the patient portal. I understand that Hancock Regional Hospital will require my proxy to sign an acknowledgment and agree to Hancock Regional Hospital's policies and procedures for use of the patient portal.

This authorization is valid until revoked by me. I understand that a written request is necessary to revoke or cancel this authorization. However, I understand that my revocation will not be effective as to uses and/or disclosures already made in reliance upon this authorization. I realize that the information used and/or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy laws.

**Patient Acknowledgment**

_____	_____
Signature of Patient	Date

**Portal User Acknowledgment**

_____	_____
Signature of Portal User	Date