2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HOSPITAL and CLINICS
STANFORD, CALIFORNIA 94305

CONSENT MYHEALTH PROXY ACCESS REQUEST FORM

Request for Online Access to Medical Records for a Minor Child

You must submit form in person to a clinic at Stanford Hospital and Clinics or University Healthcare Alliance/Menlo Medical Clinic. Photo ID will be verified upon submission.

I hereby request Stanford Hospital and Clinics (SHC) provide access to the health information in MyHealth allowable by law, of the patient named below to the following proxy representative.

Please note the following age range limitations for MyHealth. These age range limitations do not affect any legal right you have to access your child's record by other means. To request a paper copy of your child's record, contact the medical records department.

- If your child is **age 0-11:** You will be granted full access to your child's MyHealth record.
- If your child is **age 12-17:** You will be granted partial access to your child's MyHealth record. (e.g. immunizations, messaging)
- Once your child reaches **age 18,** you will no longer have access to your child's MyHealth record.

Please print legibly and complete all fields to ensure timely processing.

Patient Name ________________________ ________________________ ____________
(Under age 18) *Last* *First* *MI*

Medical Record Number (MRN): ______________________________

Phone ______________________________ **Date of Birth** _____________________
MM/DD/YYYY

Your Name________________________ ________________________ ____________
(Over age 18) *Last* *First* *MI*

Street Address ____

City ____________________________________ **State** __________ **Zip Code** ____________

Phone ______________________________ **Date of Birth** _____________________
MM/DD/YYYY

Email ____

Your Relationship to child (legal documents may be required, e.g., birth certificate, guardianship papers, power of attorney, marriage certificate):

☐ Parent ☐ Guardian ☐ Conservator ☐ Stepparent

Your Affiliation with SHC:

☐ I am a patient with MyHealth log-in ☐ I am a patient without MyHealth log-in ☐ I am not a patient

Your Signature [ ] **Date** ____________________

HIMS USE ONLY

Date Request Received: ___________ Patient Relationship Verified By: ____________________ ☐ SHC ☐ UHA

Proxy MRN: ____________ Proxy Access Approved: ☐ Yes ☐ No Letter Sent: ☐ Yes ☐ No Date Sent: _________