



Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

**CONSENT • ADULT TO ADULT MYHEALTH PROXY
SHARE ACCESS REQUEST FORM** Page 1 of 3

You must submit this form in person to a clinic at Stanford Health Care, Stanford Medicine Partners, or Stanford Health Care Tri-Valley. Photo ID will be verified upon submission.

Authorization For Use Or Disclosure Of Health Information

Patient information is confidential and is protected by law. You have access to your own health information in MyHealth (Stanford Health Care patient portal that allows secure access to health information) and Bedside (Stanford Health Care patient portal that allows secure access to health information during hospital care), and if you choose, you may authorize to “Share Access” with a Proxy such as a family member or friend. If you authorize to share access with a Proxy, the Proxy will see all your health information, including details of your care, diagnoses, medications, lab results, caregivers’ notes and observations, your emails with your caregivers, and other personal information about you and your care available in MyHealth and Bedside.

Please print clearly and complete all blanks to ensure timely processing.

PATIENT INFORMATION:

Patient Name (18+ years of age) (print clearly)

Last *First* *MI*

Street Address _____

City _____ **State** _____ **Zip Code** _____

Phone _____ **Date of Birth** _____
MM/DD/YYYY

Email Address _____

Medical Record Number: _____

STANFORD HEALTH CARE STAFF USE ONLY

Date Request Received: _____ Patient ID Verified: Yes No Proxy ID Verified: Yes No
ID Verified by: _____ ID Attached OR ID Scanned into EHR

Location: _____

Stanford Health Care DL-HIMS Proxy Requests

Stanford Medicine Partners

Stanford Health Care Tri-Valley

Fax: (510) 974-2340

Interoffice: Designated HIMS site

Interoffice: Designated HIMS site

Interoffice: MPI Department (MC 5200)

15-2991 (08/24)



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**CONSENT • ADULT TO ADULT MYHEALTH PROXY
SHARE ACCESS REQUEST FORM** Page 2 of 3

Request for Online Access to Medical Information for an Adult Patient (18+ yrs)

BY COMPLETING AND SIGNING THIS AUTHORIZATION FORM, YOU AUTHORIZE STANFORD HEALTH CARE, STANFORD MEDICINE PARTNERS, OR STANFORD HEALTH CARE TRI-VALLEY TO GRANT ACCESS TO ALL OF YOUR HEALTH INFORMATION AVAILABLE IN MYHEALTH AND/OR BEDSIDE **INCLUDING INFORMATION REGARDING HIV, DRUG/ALCOHOL USE, FAMILY PLANNING/ GENETICS AND MENTAL HEALTH, IF PRESENT**, TO THE FOLLOWING INDIVIDUAL (YOUR MYHEALTH AND/OR BEDSIDE PROXY):

PROXY INFORMATION:

**Share Access with:
Proxy Name (print clearly)**

Last *First* *MI*

Street Address _____

City _____ **State** _____ **Zip Code** _____

Phone _____ **Date of Birth** _____ **Gender** Male Female
MM/DD/YYYY

Email _____

Proxy Affiliation with Stanford Health Care:

Patient with MyHealth log-in Patient without MyHealth log-in Not a patient

If patient, Proxy Medical Record Number _____

This authorization shall expire 50 years from the date of your signature below. If you wish a different expiration date, please indicate here (optional): _____
(MM/DD/YYYY)

You may revoke this authorization at any time electronically in your MyHealth record, or you may submit a written revocation. If written, the revocation must be signed by you and sent to the Stanford Health Care Health Information Management Services (HIMS) department. The revocation is effective upon processing but will have no impact on uses or disclosures made while the authorization was valid.

HIMS USE ONLY

Date Request Received: _____ Request Verified By: _____

Stanford Health Care Stanford Medicine Partners Stanford Health Care Tri-Valley

Legal Documents Received

Proxy MRN: _____ Proxy Access Approved: Yes No Letter Sent: Yes No



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SHARE ACCESS REQUEST FORM** Page 3 of 3

Request for Online Access to Medical Information for an Adult Patient (18+ yrs)

This authorization will share access to your MyHealth and/or Bedside record. It does not allow your Proxy to (1) make health care decisions on your behalf, or (2) access your health information other than via MyHealth and Bedside. If you wish to permit other access or decision making authority, please contact the Stanford Health Care HIMS department at (650) 498-6200.

Sharing access with a Proxy to your MyHealth and/or Bedside information is your voluntary choice. If you choose not to share access to a Proxy, it will not affect your ability to obtain treatment, payment or eligibility for benefits. If you prefer to give an individual only select health information about you instead of all your health information available in MyHealth or Bedside, then please contact the HIMS department for assistance at (650) 498-6200.

Patient or Personal Representative Signature: _____

Date: _____

IF PERSONAL REPRESENTATIVE IS SIGNING THIS FORM:

Personal Representative Name (print clearly):

Last *First* *MI*

Street Address _____

City _____ **State** _____ **Zip Code** _____

Phone _____ **Date of Birth** _____ **Gender** Male Female
MM/DD/YYYY

Personal Representative Authority to Sign for Patient:

If you are not the patient and you are signing this authorization form, describe your authority to sign on behalf of the patient and please provide supporting legal documentation:

