**Patient Name** 



Addressograph or Label - Patient Name, Medical Record Number P

Page 1 of 3

You must submit this form in person to a clinic at Stanford Health Care or University Health Care Alliance/Menlo Medical Clinic. 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 a Proxy to have access also such as a family member or friend. If you authorize Proxy access, the Proxy will see all your health information available in MyHealth and Bedside, 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	МІ
Street Address		
City	State	Zip Code
Phone	Date of Birth	
		MM/DD/YYYY
Medical Record Number:		
	SHC STAFF USE ONLY	
Date Request Received:	_ Patient ID Verified: 🛄 Yes 🔲 No	Proxy ID Verified: 🔲 Yes 🔲 No
SHC DL-HIMS Proxy Requests	<u>MENLO</u> Fax: (650) 321-4897	UHA
Fax: (650) 498-5120 Interoffice: MPI Department (MC 5200)	Interoffice: Menlo HIMS (MC 5803)	Interoffice: Designated HIMS site
15-2991 (05/15)	、 · · ·	

Medical Record Number			
Medical Record Number	Madiaal	Deeevel	Muuna la au
	Medical	Record	Number

**Patient Name** 

Addressograph or Label - Patient Name, Medical Record Number

ADULT PROXY ACCESS REQUEST FORM

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# 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 (SHC) 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:**

Proxy Name (print clearly)

Last	First	МІ
Street Address		
City	State	_Zip Code
Phone	Date of Birth	
Email		MM/DD/YYYY
Proxy Affiliation with SHC:		
Patient with MyHealth log-in	Patient without MyHealth log-in	Not a patient
If patient, Proxy Medical Record Num	ber	
This authorization shall expire 50 years expiration date, please indicate here (op		-
		D/YYYY)
You may revoke this authorization at any submit a written revocation. If written, the Department. The revocation is effective made while the authorization was valid.	ne revocation must be signed by you	and sent to the SHC HIMS
	HIMS USE ONLY	
Date Request Received:	Request Verified By:	SHC I Menlo I UHA
Proxy MRN:	Proxy Access Approved: 🗋 Yes 🛛 No	Detter Sent: ☐ Yes ☐ No Date Sent:

Medical Record Number	
Patient Name	

Addressograph or Label - Patient Name, Medical Record Number

ADULT PROXY ACCESS REQUEST FORM

#### Page 3 of 3

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

This authorization gives your Proxy 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 SHC Health Information Management Services (HIMS) department at (650) 723-5721.

Giving a Proxy access to your MyHealth and/or Bedside information is your voluntary choice. If you choose not to authorize 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) 723-5721.

# Patient or Personal Representative Signature:

Date:

# **IF PERSONAL REPRESENTATIVE IS SIGNING THIS FORM:**

Personal Representative Name (print clearly):

Last	First	МІ
Street Address		
City	State	Zip Code
Phone	Date of Birth	
Personal Representative Auth		MM/DD/YYYY

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: