STANFORD HEALTH CARE
STANFORD, CALIFORNIA 94305

Addressograph or Label - Patient Name, Medical Record Number

ADULT PROXY ACCESS REQUEST FORM

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* *MI*

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
Fax: (650) 498-5120
Interoffice: MPI Department (MC 5200)

MENLO
Fax: (650) 321-4897
Interoffice: Menlo HIMS (MC 5803)

UHA
Interoffice: Designated HIMS site

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* *MI*

Street Address_____

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

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

Email_____

Proxy Affiliation with SHC:

☐ 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 SHC 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:_____ ☐ SHC ☐ Menlo ☐ UHA
☐ Legal Documents Received
Proxy MRN:_____ Proxy Access Approved: ☐ Yes ☐ No Letter Sent: ☐ Yes ☐ No
Date Sent:_____

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* *MI*

Street Address_____

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

Phone _____ **Date of Birth**_____

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:

_____

_____

_____