Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HEALTH CARE
STANFORD, CALIFORNIA 94305

CONSENT • ADULT TO MINOR MYHEALTH PROXY SHARE ACCESS REQUEST FORM

You must submit form in person to a clinic at Stanford Health Care (SHC), University Healthcare Alliance, or Stanford Health Care-ValleyCare. Photo ID will be verified upon submission.

I hereby request Stanford Health Care (SHC), University Healthcare Alliance (UHA), or Stanford Health Care-ValleyCare (SHC-VC) provide access to the health information in MyHealth allowable by law, of the patient names 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 appropriate 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 (See Consent - Adult to Adult MyHealth Proxy Share Access Request Form).

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** ______________ **Gender** ❑ Male ❑ Female
MM/DD/YYYY

Email ______________________

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

❑ Mother ❑ Father ❑ Guardian ❑ Conservator ❑ Stepparent

Your Affiliation with SHC:

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

Adult Requester Signature ____________ ____________ ______________________
DATE TIME SIGNATURE

____
PRINT NAME

HIMS USE ONLY

Date Request Received: ______________ Patient Relationship Verified by: ____________ ❑ SHC ❑ UHA ❑ SHC-VC

Proxy MRN: ____________ Proxy Access Approved: ❑ Yes ❑ No Letter Sent: ❑ Yes ❑ No Date Sent: ____________