Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HEALTH CARE
STANFORD, CALIFORNIA 94305

CONSENT • MYHEALTH PROXY SHARE ACCESS REVOCATION FORM

You may revoke Proxy access in MyHealth, or if you prefer to use this form, please return it to a clinic at Stanford Health Care, University HealthCare Alliance, or Stanford Health Care - ValleyCare. Photo ID will be verified upon submission.

Revocation of MyHealth and Bedside Proxy Access - complete this form only if you would like to revoke or cancel your Proxy's access to your health information in MyHealth and Bedside.

PATIENT INFORMATION – *print clearly*:

Patient Name: _____
Last *First* *MI*

Street Address _____

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

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

Medical Record Number (MRN): _____

By signing this form, I revoke the prior authorization that gave the Proxy below access to my health information in MyHealth and Bedside.

PROXY INFORMATION – *print clearly*:

Proxy Name: _____
Last *First* *MI*

Street Address _____

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

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

Email _____

Proxy Medical Record Number (MRN): _____

SIGNATURE REQUIRED ON REVERSE SIDE →

SHC STAFF USE ONLY

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

SHC DL-HIMS Proxy Request
Interoffice: MPI Department (MC 5200)

UHA
Interoffice: Designated HIMS site

SHC - VC
Interoffice: Designated HIMS site

By signing this Proxy Revocation Form, you are requesting that Stanford Health Care (SHC) revoke/cancel your Proxy's access to your health information in MyHealth and Bedside.

The time to process this request generally may take up to five business days, during which time Proxy access will remain in place. You may immediately revoke your Proxy's access to your health information in MyHealth and Bedside by signing into your MyHealth or Bedside account and selecting the option to revoke your Proxy's access.

If you have any questions about this authorization to cancel/revoke your Proxy's access to MyHealth and Bedside, you may contact the Stanford Health Care Health Information Management Services (HIMS) department 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:

_____

_____

_____

HIMS USE ONLY

Date Request Received: _____ Request Verified By: _____ ❑ SHC ❑ UHA ❑ VC

❑ Legal Documents Received

Proxy MRN: _____ Proxy Revocation Completed: ❑ Yes ❑ No Letter Sent: ❑ Yes ❑ No

Date Sent: _____