



Medical Record Number

Patient Name

**ADULT PROXY ACCESS REQUEST FORM**

Addressograph or Label - Patient Name, Medical Record Number

**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: \_\_\_\_\_

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**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)  
15-2991 (05/15)

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

**UHA**  
Interoffice: Designated HIMS site

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**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* \_\_\_\_\_ *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: \_\_\_\_\_

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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.

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**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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_