Stanford Children's Health | Lucile Packard Children's Hospital Stanford
Lucile Salter Packard Children's Hospital
STANFORD UNIVERSITY MEDICAL CENTER ● 725 Welch Road, Palo Alto, CA 94304

Consent Form • MyChart Adult to Adult Proxy Form

Medical Record Number

Patient Name

Addressograph Stamp – Patient Name, Medical Record Number

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

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 MyChart (Stanford Children's Health patient portal that allows secure access to health information) and if you choose, you may authorize to "Share Access" with a Proxy. If you authorize Proxy access, the Proxy will see all your health information available in MyChart, 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 MyChart. Your proxy will not be able to request your records through their MyChart proxy accounts.

Please print clearly and complete all blanks to ensure timely processing.

PATIENT INFORMATION

Patient's Last Name: _____ **First:**_____ **M:**_____

Date of birth: _____ **Medical Record number:** _____

Indicate if patient is part of multiple births: ❑Twin ❑Triplets ❑Other:_____

Street Address: _____

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

Phone Number: _____

BY COMPLETING AND SIGNING THIS AUTHORIZATION FORM, YOU AUTHORIZE STANFORD CHILDREN'S HEALTH TO GRANT ACCESS TO ALL OF YOUR HEALTH INFORMATION AVAILABLE IN MYCHART ***INCLUDING INFORMATION REGARDING HIV, DRUG/ALCOHOL USE, FAMILY PLANNING, GENETICS AND MENTAL HEALTH, IF PRESENT,*** TO THE FOLLOWING INDIVIDUAL(YOUR MYCHART):

PROXY INFORMATION Share Access with Proxy (print clearly):

Proxy Last Name: _____ **First:**_____ **M:**_____

Date of birth: _____ **Phone Number:** _____ **Email:** _____

Street Address: _____

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

Proxy Affiliation with Stanford Children's Health:

❑ Patient with MyChart log-in ❑ Patient without MyChart long in ❑ Not a patient

If patient, Proxy Medical Record Number: _____

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CAUTIONS BEFORE SIGNING

This authorization shall expire 5 years from the date of your signature below.

You may revoke this authorization at any time. You may submit a written revocation signed by you and send to SCH HIMS Department. The revocation is effective upon processing but will have no impact on use or disclosures made while the authorization was valid.

This authorization gives your Proxy access to your MyChart account. It does not allow your Proxy to (1) make health care decisions on our behalf, (2) access your health information other than via MyChart, or (3) request your records through their MyChart proxy account.

Sharing access with a Proxy to your MyChart 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.

SIGNATURE AND DATE

Please sign and date this form to authorize Proxy access as stated on this form.

_____ _____

SIGNATURE (Patient or Properly Designated Representative) Date

IF REPRESENTATIVE IS SIGNING THIS FORM

Representative Information (print clearly):

Proxy Last Name: _____ **First:**_____ **M:**_____

Date of birth: _____ **Phone Number:** _____

Street Address: _____

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

If you are not the patient and you are signing this authorization form please provide supporting legal documentation supporting your relationship.