Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HEALTH CARE
STANFORD, CALIFORNIA 94305

**CONSENT MYHEALTH SHARE ACCESS REQUEST FORM**

## Request for Online Access to Medical Records for a Minor Child

You must submit form in person to a clinic at Stanford Health Care (SHC), University Healthcare Alliance/ Menlo Medical Clinic, 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 named 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 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.

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 child** (legal documents may be required, e.g., birth certificate, guardianship papers, power of attorney, marriage certificate):

☐ Parent ☐ Guardian ☐ Conservator ☐ Stepparent

**Your Affiliation with SHC:**

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

**Your Signature** _____ **Date** _____

### 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: _____