Proxy Access Form (Children Under 18)

SUTTER HEALTH USE ONLY
MRN:
DOB:
Doc Type:
DOS:

Select Your Sutter Affiliate / Hospital

☐ Sutter Medical Foundation ☐ Sutter East Bay Medical Foundation ☐ Sutter Gould Medical Foundation
☐ Palo Alto Medical Foundation ☐ Sutter Pacific Medical Foundation
☐ Sutter Community Connect (write provider's name): ____________________
☐ A Sutter Hospital (write hospital name): ____________________

Request for Online Access to Medical Records for a Minor Child

I hereby request that the Sutter Health affiliate provides access to the health information in My Health Online allowable by law, of the patient named below to the following individual. For stepparents, please complete the "**Written Authorization for a Stepparent to Access the Medical Record of a Minor Child**" form found on this website. Please complete all fields and print legibly to ensure timely processing.

Patient Name: ____________________ ____________________ __________
(Under Age 18) Last First MI

Phone: (________) ____________________ **SSN**: ______________ **DOB**: ____________________
Last 4 Digits Only MM/DD/YYYY

Proxy Representative: ____________________
Please Print Legibly

Street Address: ____________________

City: ____________________ **State**: ____________ **ZIP Code**: ____________________

Phone: (________) ____________________ **SSN**: ______________ **DOB**: ____________________
Last 4 Digits Only MM/DD/YYYY

Email: ____________________

Relationship to child*: ☐ Parent ☐ Guardian ☐ Conservator
*Legal documents may be required, e.g., marriage certificate, birth certificate, guardianship papers, power of attorney.

Proxy Representative Signature: ____________________ **Date**: ____________

Fax to: (877) 607-6484 **or** **Mail to:** Patient Services Contact Center
P.O. Box 255386
ATTN: My Health Online Proxy
Sacramento, CA 95865-5386

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MRN: ____________________ Department / Care Center: ____________________
Patient ID Verified By: ____________________ Physician Name: ____________________