Sutter Health

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

Written Authorization for a Stepparent to Access the Medical Record of a Minor Child

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): _____

This request for written permission is required by state and federal law. Please complete all fields and print legibly to ensure timely processing.

Patient Name: _____ _____ _____
Last First MI

Phone: (_____) _____ **SSN (Last 4 Digits)**: _____ **DOB**: _____

I grant authorization to the following individual to access the health information in My Health Online, for the patient named above:

Stepparent Name: _____

Street Address: _____

City: _____ **State**: _____ **ZIP Code**: _____

Phone: (_____) _____ **SSN (Last 4 Digits)**: _____ **DOB**: _____

Email: _____

Natural Parent Name: _____

Street Address: _____

City: _____ **State**: _____ **ZIP Code**: _____

Phone: (_____) _____ **SSN (Last 4 Digits)**: _____ **DOB**: _____

Email: _____

Relationship to Patient Named Above: ☐ Natural Parent ☐ Guardian

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Parent/Stepparent Verified By: _____ Date: _____

Sutter Health
We Plus You

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Written Authorization for a Stepparent to Access the Medical Record of a Minor Child

The recipient may use my health information only for the following purpose:

To access medical information and services on behalf of a minor child via My Health Online. This authorization does NOT allow the proxy representative to access the patient's health information other than via My Health Online.

I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment. This authorization shall remain valid until terminated electronically or in writing by My Health Online, the proxy representative or once the child reaches 18 years of age, whichever comes first. If written, the revocation must be signed on the patient's behalf and sent to the Patient Services Contact Center. The revocation is effective upon receipt, but will have no impact on uses or disclosures made while the authorization was valid.

Restriction: California law prohibits the proxy representative from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

I HAVE A RIGHT TO A COPY OF THIS AUTHORIZATION

Copy Requested? _____ Yes _____ No **Copy Received?** _____ Yes _____ No

_____ _____
Natural Patient / Guardian Signature **Date**

_____ _____
Stepparent 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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Parent/Stepparent Verified By: _____ Date: _____