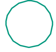 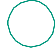 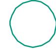 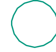 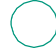

3ROI

3ROI

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: ____________________ ________________________ ______________
(Under age 18) Last First MI

Tel: (_____)______- _______ SSN: (last 4 digits)______ Date of Birth:___/___/______

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

Stepparent: ____

Street Address: ____

City: ________________________ State: ________________ Zip: ____________

Tel: (_____)______- _______ SSN: (last 4 digits)______ Date of Birth:___/___/______

Email Address:____

Natural Parent or
Guardian:____

Street Address: ____

City: ________________________ State: ________________ Zip: ____________

Tel: (_____)______- _______ SSN: (last 4 digits)______ Date of Birth:___/___/______

Email Address:____

Relationship to patient named above: ☐ **Natural Parent** ☐ **Guardian**

I HAVE A RIGHT TO A COPY OF THIS AUTHORIZATION (refer to backside of form for additional information regarding authorization)

Copy requested: ☐ Yes ☐ No Copy received: ☐ Yes ☐ No

____ ____________________
Natural Parent/Guardian Signature Date/Time

____ ____________________
Stepparent Signature Date/Time

PATIENT LABEL

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

***To access medical information and services on behalf of a minor child via* MyChart.**

This authorization does NOT allow the proxy representative to access the patient's health information other than via MyChart.

I may refuse to sign this authorization and my refusal will not affect the patient's ability to obtain treatment. This authorization shall remain valid until terminated electronically or in writing by MyChart or 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 Health Information Management department. 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 the patient's 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.

Fax to: (925) 947-3235 or Mail to: John Muir Health
Health Information Management
ATTN: MyChart Proxy
5003 Commercial Circle
Concord, CA 94520
(925) 941-2655

JMH USE ONLY:

Parent/Stepparent Verified by: ______________________________ Date: ___________________

PATIENT LABEL

JOHN MUIR HEALTH