Tully-Wihr 800-789-6594

3ROI

Authorization for Use or Disclosure of Health Information

This authorization for use or disclosure of my health information via MyJohnMuirHealth is required by state and federal law.

Please complete all fields and print legibly to ensure timely processing.

Patient Name: ____________________ ____________________ ____________________
Last First MI

Tel: (_____) ______ - _______ SSN:____ - ___ - _______ Date of Birth:___/___/______

I Hereby Authorize The Use or Disclosure of My Health Information

I hereby authorize John Muir Health, John Muir Physician Network, and/or John Muir Behavioral Health (collectively, "John Muir") to grant access to *all* of my health information in MyJohnMuirHealth, *including information regarding HIV, Drug/Alcohol use and Mental Health if present*, to the following individual:

Proxy Representative: ____

Street Address: ____

City: ______________________ State: ________________ Zip: ______________

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

Email Address:____

Relationship to me:*
- ☐ Spouse
- ☐ Adult Child (18+ Years)
- ☐ Care Giver
- ☐ Conservator
- ☐ Guardian
- ☐ Other

*Legal documents may be required to establish relationship, e.g., marriage certificate, birth certificate, guardianship papers, power of attorney.

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

____ ____________________________
Patient Signature Date/Time

PROXY-01 (9/23/13)

PROXY ACCESS FORM (ADULTS 18+)

PATIENT LABEL

Print Name:

DOB:

MR#:

WHITE - CHART YELLOW - PATIENT

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

***To access medical information and services on my behalf via* MyJohnMuirHealth.**

This authorization does NOT allow my Proxy Representative to (1) make health care decisions on my behalf OR (2) access my health information other than via MyJohnMuirHealth.

This authorization shall be valid until either: (a) terminated by the Patient or Proxy Representative electronically or in writing, or (b) five (5) years from the signature date below, whichever comes first. I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment. I may revoke this authorization at any time electronically or in writing. If written, the revocation must be signed by me or on my 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 your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection may not extend to recipients outside the state of California.

Fax to: (925) 947-3235 or Mail to: John Muir Health
Health Information Management
ATTN: MyJohnMuirHealth Proxy
1400 Treat Blvd, 2nd Floor
Walnut Creek, CA 94597
(925) 941-2655

JMH USE ONLY:

MRN: ____________________________________

Parent/Guardian ID Verified by: __________________________ Date: _________________

PROXY-01 (9/23/13)

PROXY ACCESS FORM (ADULTS 18+)

WHITE - CHART YELLOW - PATIENT

PATIENT LABEL

Print Name:

DOB:

MR#: