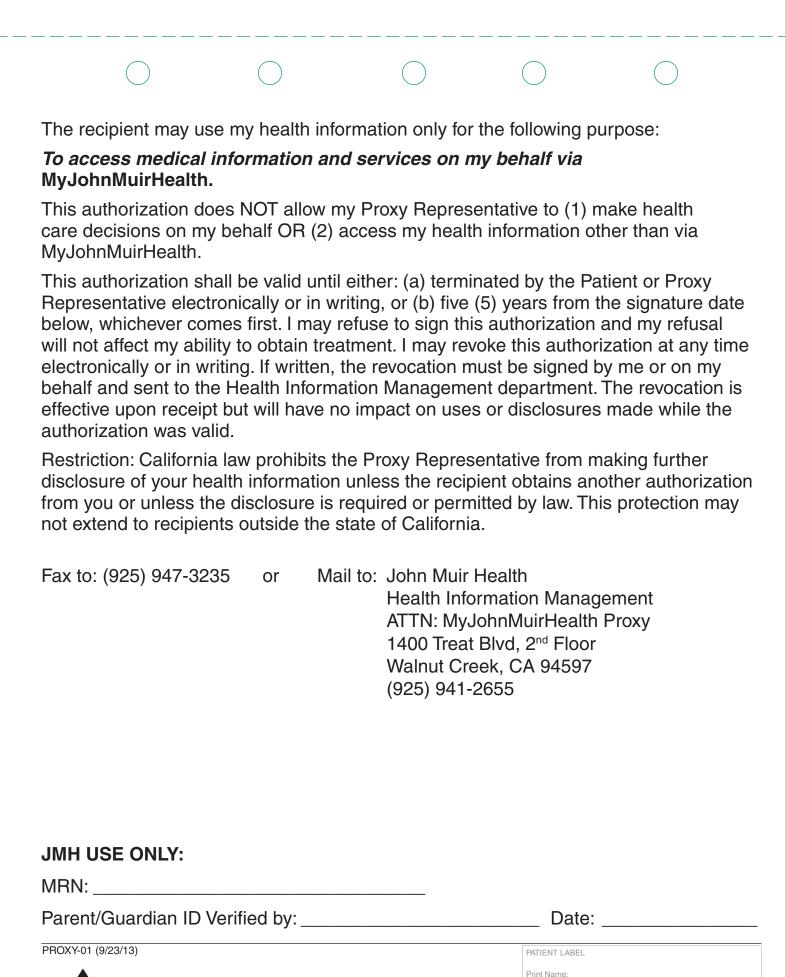


3ROI

Authoriza	ation for Use	or Disclosure	of Health In	formation			
This authorn MyJohnM Please co	orization for uirHealth is mplete all fi	use or disclos required by sta elds and print	ure of my he ate and fede legibly to en	ealth inform ral law. sure timely		J.	
Name:	Last		First		MI		
Tel: () -	SSN:		. [Date of Birth	n: /	/
	-	ne Use or Disc					
Muir Beha informatio	avioral Healt n in MyJohr	nn Muir Health h (collectively, MuirHealth, <i>ir</i> h if present, to	"John Muir" ocluding info) to grant a rmation reg	ccess to all garding HIV,	of my h	nealth
•	tative:						
Street Add	dress:						
City:	ty: State:			Zip:			
Tel: (_)	SSN:	(last 4 digits	s)[Date of Birth	n:/_	/
Email Add	dress:						
	hip to me:*	□ Spouse□ Adult Child	d (18+ Years				
birth certif I HAVE A additional	ficate, guard RIGHT TO <i>i</i> information	y be required in the state of t	s, power of a HIS AUTHO norization)	attorney. RIZATION	(refer to ba	ckside	
Copy requ	uested: 🗆 `	res ⊔ No	Copy re	eceivea: [□ Yes □ N	NO	
Patient Signature	gnature			 Dat	e/Time		
PROXY-01 (9/23/	(13)				PATIENT LABEL		
	OHN MUI	R			Print Name:		
PRO	XY ACCESS I	FORM (ADULTS	18+)		DOB:		
WHITE - CHART YELLOW - PATIENT					MR#:		



PROXY ACCESS FORM (ADULTS 18+)

John Muir