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 ☐ Care Giver ☐ Guardian
☐ Adult Child (18+ Years) ☐ Conservator ☐ 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)

JOHN MUIR HEALTH

PROXY ACCESS FORM (ADULTS 18+)

WHITE - CHART YELLOW - PATIENT

PATIENT LABEL
Print Name:
DOB:
MR#:

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)

JOHN MUIR HEALTH

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WHITE - CHART YELLOW - PATIENT

PATIENT LABEL

Print Name:

DOB:

MR#: