









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: First (Under age 18) Last MI Tel: () - SSN: (last 4 digits) Date of Birth: / / I grant authorization to the following individual to access the health information in MyJohnMuirHealth, 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: \square Yes \square No Copy received: \square Yes \square No Natural Parent/Guardian Signature Date/Time Stepparent Signature Date/Time PROXY-02 (11/20/14)

The recipient may use the health information only for the following purpose:						
To access med MyJohnMuirH		mation and s	services on l	behalf of a min	or child via	
This authorizat health informat					ess the patient's	
to obtain treatmor in writing by reaches 18 years signed on the p	nent. This a MyJohnMu ars of age, vo patient's be ne revocation	outhorization so the sire of the whichever contains the sire of the sent of the sire of th	shall remain the proxy represented in the mes first. If we to the Health upon receipt	valid until termir esentative, OR or ritten, the revoo n Information Ma	ation must be	
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) 94	47-3235	or Mail t	ATTN: My 1400 Trea	ormation Manag JohnMuirHealth It Blvd, 2 nd Floor eek, CA 94597	Proxy	
JMH USE ONL						
Parent/Steppar	ent Verified	d by:		Date:		
PROXY-02 (11/20/14)				PATIENT LABEL		