3ROI

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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 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: ☐ 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* MyJohnMuirHealth.**

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

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 MyJohnMuirHealth 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: MyJohnMuirHealth Proxy
1400 Treat Blvd, 2nd Floor
Walnut Creek, CA 94597
(925) 941-2655

JMH USE ONLY:

Parent/Stepparent Verified by: _____ Date: _____

PATIENT LABEL