Sutter Health
We Plus You

Proxy Access Form (Adults 18+)

SUTTER HEALTH USE ONLY
MRN:
DOB:
Doc Type:
DOS:

Select Your Sutter Affiliate / Hospital

☐ Sutter Medical Foundation ☐ Sutter East Bay Medical Foundation ☐ Sutter Gould Medical Foundation
☐ Palo Alto Medical Foundation ☐ Sutter Pacific Medical Foundation
☐ Sutter Community Connect (write provider's name): _____
☐ A Sutter Hospital (write hospital name): _____

Authorization for Use or Disclosure of Health Information

This authorization for use or disclosure of my health information via My Health Online is required by state and federal law. Please complete all fields and print legibly to ensure timely processing.

Patient Name: _____ _____ _____
Last First MI

Phone: (_____) _____ **SSN**: _____ **DOB**: _____
Last 4 Digits Only MM/DD/YYYY

I Hereby Authorize the Use or Disclosure of my Health Information

I hereby authorize the Sutter Health affiliate to grant access to all of my health information in My Health Online **including information regarding HIV, Drug/Alcohol use and Mental Health if present**, to the following individual:.

Proxy Representative: _____
Please Print Legibly

Street Address: _____

City: _____ **State**: _____ **ZIP Code**: _____

Phone: (_____) _____ **SSN**: _____ **DOB**: _____
Last 4 Digits Only MM/DD/YYYY

Email: _____

Relationship to me*: ☐ Spouse ☐ Caregiver ☐ Guardian ☐ Adult Child (18+ Years) ☐ Conservator ☐ Other
*Legal documents may be required, e.g., marriage certificate, birth certificate, guardianship papers, or power of attorney.

SUTTER HEALTH USE ONLY

MRN: _____ Department / Care Center: _____

Patient ID Verified By: _____ Physician Name: _____

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

To access medical information and services on my behalf via My Health Online. 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 My Health Online.

This authorization shall be valid until terminated by the Patient or Proxy Representative electronically or in writing. 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 Patient Services Contact Center. 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.

I HAVE A RIGHT TO A COPY OF THIS AUTHORIZATION

Copy Requested? _____ Yes _____ No **Copy Received?** _____ Yes _____ No

_____ _____

Patient Signature **Date**

Fax to: (877) 607-6484 **or**
Mail to: Patient Services Contact Center
P.O. Box 255386
ATTN: My Health Online Proxy
Sacramento, CA 95865-5386

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