SANTA CLARA VALLEY MEDICAL CENTER Hospital & Clinics
myHealth ONLINE

[Affix Patient Sticker Here]

Patient Name

MRN

Date

Request Form for Proxy Access to myHealth Online for Minor Patients & Patients with Diminished Capacity

I request that Santa Clara Valley Health & Hospital System provide me with Proxy access to the health information in myHealth Online of the minor patient or diminished capacity patient named below to the extent allowable by law.

Please return this completed form to the clinic.

Patient:

Full Legal Name: _____

Medical Record Number: _____

Birth date (MM/DD/YYYY): _____

Proxy Representative (must be age 18 or older, unless teen parent):

Full Legal Name: _____

Birth date (MM/DD/YYYY): _____

Mailing Address:

_____

_____

Street Address, City, State, Zip Code

E-mail: _____

Optional: Is the proxy representative a patient at SCVHHS?

□ Yes □ No

**This will allow us to link the patient's record to your current MHO account.*

If yes, please provide your Medical Record Number: _____

[Affix Patient Sticker Here]

Patient Name

MRN

Date

Request Form for Proxy Access to myHealth Online for Minor Patients & Patients with Diminished Capacity

Relationship to patient: □ Parent □ Guardian □ Conservator

Proxy representatives **may need to present documentation** to support their authority to access the patient's health information, such as:

a. Birth certificate
b. Guardianship (such as court order or custody agreement)
c. Caregiver's Authorization Affidavit
d. Advance Directive or Power of Attorney for HealthCare

Proxy Representative Signature: _____

Date: _____

Clinic documentation only below this line. Only applicable for patients with Diminished Capacity.

Physician Attestation that Patient Lacks Capacity to Consent:

To assure continued coordination of care for the above patient, it is important that the proxy representative identified above have full access to myHealth Online. This patient has clinical and developmental challenges that prevent him/her being able to consent to care.

Physician Signature: _____ Date: _____

Physician Name: _____