Sutter Health
We Plus You

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

Written Authorization for a Stepparent to Access the Medical Record of a Minor Child

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 12) ______________________ Last ______________________ First ________ MI

Phone ______________________ **SSN** ______________________ (Last 4 digits only) **DOB** ______________________

I grant authorization to the following individual to access the health information in My Health Online, for the patient named above:

Stepparent ____

Street Address ____

City ______________________ **State** ________ **Zip Code** ______________________

Phone ______________________ **SSN** ______________________ (Last 4 digits only) **DOB** ______________________

E-mail Address ____

Natural Parent or Guardian ____

Street Address ____

City ______________________ **State** ________ **Zip Code** ______________________

Phone ______________________ **SSN** ______________________ (Last 4 digits only) **DOB** ______________________

E-mail Address ____

Relationship to patient named above: ☐ Natural Parent ☐ Guardian

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Parent/Stepparent Verified By: ______________________ Date: ______________________

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

I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment. This authorization shall remain valid until terminated electronically or in writing by My Health Online, the proxy representative or once the child reaches 12 years of age, whichever comes first. If written, the revocation must be signed on the patient's 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 does 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

______________________________ ______________
Natural Parent/Guardian Signature   Date

______________________________ ______________
Stepparent Signature   Date

Fax to: (877) 607-6484

Mail to: Patient Services Contact Center
ATTN: My Health Online Proxy
P.O. Box 255386
Sacramento, CA 95865-5386

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