



MySutterOnline USE ONLY

MRN:
Work Type: 085
DOS:

Authorization For Use Or Disclosure Of Health Information

This authorization for use or disclosure of my health information via MySutterOnline is required by state and federal law.

Patient Name: _____
Last First MI

DOB: _____ Phone: _____ SSN: ____/____/____

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 MySutterOnline *including information regarding HIV, Drug/Alcohol use and Mental Health if present*, to the following individual:

_____ effective _____
Proxy Representative (please print) Date

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ SSN: _____ DOB: _____

***Relationship to me:**

- Spouse
- Adult Child (18+ years)
- Care Giver
- Conservator
- Guardian
- Other _____

*Legal documents may be required, e.g., marriage certificate, birth certificate, guardianship papers, power of attorney.

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

