



**MySutterOnline USE ONLY**

MRN:  
Work Type: 085  
DOS:

**Request for Online Access to Medical Records for a Minor Child**

This request for access to health information via MySutterOnline is required by state and federal law.

Patient Name: \_\_\_\_\_  
Last First MI

DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ SSN: \_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby request that the Sutter Health affiliate provide access to the health information in MySutterOnline allowable by law, of the patient named above to the following individual:

\_\_\_\_\_ effective \_\_\_\_\_  
Proxy Representative (please print) Date

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ SSN: \_\_\_\_/\_\_\_\_/\_\_\_\_

DOB: \_\_\_\_\_ E-mail address: \_\_\_\_\_

\*Relationship to child:

Parent  Conservator  Guardian  Stepparent\*\*

\*Legal documents may be required, such as birth certificate, guardianship papers and/or power of attorney.

\*\*Written permission from an authorized parent must be submitted for a stepparent to access the child's medical record.

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

*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 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 MSO, 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 Sutter Health affiliate. The revocation is effective upon receipt, but will have no impact on uses or disclosures made while the authorization was valid.

I HAVE A RIGHT TO A COPY OF THIS AUTHORIZATION.  
Copy requested [ ] Yes [ ] No                      Copy received [ ] Yes [ ] No

\_\_\_\_\_  
Proxy Representative Signature

\_\_\_\_\_  
Date

<b>MySutterOnline Use Only</b> Patient/Proxy ID verified by: _____ Date: ____/____/____
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