SANTA CLARA VALLEY MEDICAL CENTER
Hospital & Clinics
myHealth ONLINE

[Affix Patient Sticker Here]

Patient Name

MRN

Date

# Authorization to Grant Access to Health Information in myHealth Online for Adult Patients

**Terms and Conditions:** Patients of Santa Clara Valley Health & Hospital System can grant another adult at least 18 years of age or older access to their medical, mental health and substance use treatment information via myHealth Online. If you would like another adult such as a spouse, caregiver, or family member to have access to the information available in your myHealth Online account, the following Authorization Form must be completed and signed. Return this completed form to your clinic.

Adult representatives (proxies) of adult patients will receive full access to the same information and features available as the patient. (See our User Guide for more details of the features.) This authorization does NOT allow your proxy representative to 1) make health care decisions on your behalf OR 2) access your health information other than information available via myHealth Online.

**I understand that the health information** a proxy representative can access once given permission **may include:**

1. Viewing portions of my health record, including medical information, mental health, and substance use treatment information;
2. Requesting renewals of medications;
3. Viewing test results;
4. Scheduling or requesting appointments; and
5. Sending and responding to non-urgent, secure e-Messages with your providers.

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**Your Rights**: I understand that I have a right to cancel this authorization at any time. Unless purposefully cancelled, this Authorization will never expire. myHealth Online proxy access may be revoked online through myHealth Online, by visiting your clinic, or by emailing myHealthonline@hhs.sccgov.org . A cancellation will not apply to actions already taken by SCVHHS under this authorization.

I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on my giving or refusing to give this authorization. I also understand that I may refuse to sign this authorization. A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization. Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such re-disclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA), although information protected by 42 CFR Part 2 continues to be subject to that protection. In addition, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

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**AUTHORIZATION:**

I hereby authorize Santa Clara Valley Health & Hospital System (SCVHHS), **to grant myHealth Online access, including information regarding HIV, drug/alcohol use and mental health if present, to the below named proxy representative:**

**Proxy Representative:**

Full Legal Name: ______________________________________________

Birth date (MM/DD/YYYY): _________________________________

Mailing Address: _____________________________________________

City:_____________________State:__________Zip:____________________

E-mail: _______________________________________________________

Relationship to patient: _____________________________________________

Is the Proxy Representative a SCVHHS patient? □ Yes □ No

*If yes, proxy representative's Medical Record Number: ____________________

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

**I affirm that I have read and agree to these myHealth Online terms and conditions and request proxy access be granted to my record as indicated above.**

Patient Signature: ______________________________________________

Date: ______________________________________________