

*PAMF USE ONLY*

MRN:

WORK TYPE: 085

DOS:

Request for Online Access to Medical Records for a Minor Child  
under 12 years of age

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

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

I hereby request that the Palo Alto Medical Foundation (PAMF) provide access to the health information in PAMFOnline 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\*\*

If the proxy representative is a PAMF patient and has not yet established a PAMFOnline account, please submit a PAMFOnline Release of Information form in addition to this request form.

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

*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.*

This authorization shall remain valid until terminated electronically or in writing by PAMF, 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 Palo Alto Medical Foundation. The revocation is effective upon receipt, but will have no impact on uses or disclosures made while the authorization was valid.

PAMF reserves the right to terminate the proxy access to the PAMFOnline personal health record at any time at PAMF's discretion.

**I HAVE A RIGHT TO A COPY OF THIS AUTHORIZATION.**

Copy requested  Yes  No

Copy received  Yes  No

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

\_\_\_\_\_  
Date

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Patient/Proxy ID verified by: \_\_\_\_\_ Date: \_\_\_\_\_

Mail to: Palo Alto Medical Foundation  
ATTN: PAMFOnline Proxy  
P.O. Box 51477  
Palo Alto, CA 94301-9877  
Fax to: (650) 565-4431