PATIENT NAME_____
MEDICAL RECORD #_____
BIRTHDATE_____

**AUTHORIZATION FOR OTHERS TO
ACCESS MY PROTECTED HEALTH
INFORMATION VIA MYCHART**
Page 1 of 2

I hereby authorize UC Davis Health System to release all health information in my medical record that is available via MyChart. This includes releasing content related to drug and alcohol abuse, mental health, HIV/AIDS test results, and genetic testing information as specified in the MyChart Terms & Conditions.

Grant MyChart Access To:

NAME _____ DATE OF BIRTH (required)_____
Specify name of Patient Representative to receive access

ADDRESS_____
Street Address, City, State, Zip Code

EMAIL ADDRESS (required) _____
Patient Representative's Email Address

☐ Patient Representative **is** a UC Davis PATIENT

Patient Representative Medical Record (required)_____

☐ Patient Representative **is not** a UC Davis PATIENT

Relationship to the Patient: (check one)
☐ Adult for a Minor Child (age: 0-17) ☐ Patient Representative of Adult Patient (age: 18+)
Note: Legal documents may be required, e.g., power of attorney for healthcare, guardianship papers

Due to California State confidentiality laws specific to teen patients between the ages of 12 to 17, Medium access is granted to the patient's representative by Health Information Management. Full access to MyChart could be granted to the patient's representative when medical conditions are appropriate and are facilitated by the patient's care team contacting Health Information Management. Medium access allows secure messaging, appointment requests, access to immunization summary and allergies.

The purpose of this request is for: (check one)
☐ New access for a patient representative to access Medical Records via MyChart
☐ Request renewal for a patient representative to access Medical Records via MyChart

PATIENT NAME_____

MEDICAL RECORD #_____

BIRTHDATE_____

NOTICE / Restriction: California law prohibits patient representatives from making further disclosure of the patient's health information, unless the recipient obtains an additional authorization from the patient or the disclosure is required or permitted by law. The state or federal confidentiality law protections may not extend to recipients outside the State of California, or to someone who is not legally required to keep it confidential.

Information available in MyChart includes current medical information and will update as you continue to receive health care services in the future.

YOUR RIGHTS

As the patient/patient representative, you have the right to request a copy of this authorization. A copy is considered as valid as the original. Refusal to sign this request will not affect the patient's right to obtain treatment. The patient/patient representative may revoke access at any time via their MyChart account. Revocation may also be submitted to the Health Information Management Department via mail, fax or email. Revocation will take effect immediately upon receipt of your revocation request or based upon the request from UC Davis providers.

You may submit the completed Request to Access MyChart form, along with any required documentation or Request for Revocation, by any of the following methods:

Fax:	(916)734-2126
Email:	mychartactivation@ucdmc.ucdavis.edu
US mail:	UC Davis Health System, Health Information Management, Medical/Legal Release of Information Unit
	2315 Stockton Blvd. MRB-12, Sacramento, CA 95817

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this authorization for MyChart access **will expire** on _____ or as restricted by access level / relationship type, agreed upon in the MyChart Terms & Conditions.

By signing below I authorize the MyChart access disclosure and I have read, understand and agree to the MyChart Terms & Conditions. I authorize all lab/test results to be released automatically via MyChart and understand that in some cases, lab/test results will be released without prior provider review or without prior consultation between the patient and the health care provider.

_____   _____
Print Name of Patient   Signature of Patient

_____   _____
Print Name of Patient Representative   Signature of Patient Representative

_____   _____
Date   Relationship to Patient