Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HEALTH CARE
STANDFORD MEDICINE PARTNERS
STANFORD HEALTH CARE TRI-VALLEY
STANFORD MEDICAL CHILDREN'S HEALTH
PACKARD CHILDREN'S HEALTH ALLIANCE

CONSENT DECISION TO RESCIND HEALTH INFORMATION EXCHANGE EXEMPTION

PATIENT REQUEST TO RESCIND EXEMPTION FROM PARTICIPATION IN ELECTRONIC HEALTH INFORMATION EXCHANGE

By my signature dated below, I hereby notify Stanford Health Care, Stanford Medicine Partners, Stanford Health Care Tri-Valley, Stanford Medical Children's Health, and Packard Children's Health Alliance, that I allow release of my Stanford Health Care, Stanford Medicine Partners, Stanford Health Care Tri-Valley, Stanford Medical Children's Health, or Packard Children's Health Alliance health information via secure electronic health information exchange to my non-Stanford Health Care, non-Stanford Medicine Partners, non-Stanford Health Care Tri-Valley, non-Stanford Medical Children's Health, or non-Packard Children's Health Alliance health care providers as allowable by law.

Name of patient (please print):

_____

Name of legal representative signing this form, if applicable (please print):

_____

Address of patient or legal representative signing this form (please print):

_____

Phone number of patient or legal representative signing this form:

_____

If you are not the patient and you are signing this form, describe your authority to sign on behalf of the patient and provide supporting legal documentation:

_____

Legal Representative's Name (print) and Relationship

Signature of patient or legal representative: _____ *Date:* _____

*** A COPY OF THIS FORM MUST BE GIVEN TO THE PATIENT ***