Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HEALTH CARE
UNIVERSITY HEALTHCARE ALLIANCE
STANFORD HEALTH CARE - VALLEYCARE
STANFORD 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 (SHC), the University Healthcare Alliance (UHA), Stanford Health Care-ValleyCare (SHC-VC), Stanford Children's Health (SCH), and Packard Children's Health Alliance (PCHA), that I allow release of my SHC, UHA, SHC-VC, SCH, or PCHA health information via secure electronic health information exchange to my non-SHC, non-UHA, non-SHC-VC, non-SCH, or non-PCHA 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 ***