TODAY'S DATE _____ PATIENT SOCIAL SECURITY #____-____-____

PATIENT NAME _____ DATE OF BIRTH_____
LAST FIRST M.I.

SEX: F____ M____ BIRTH WEIGHT: _____lbs _____oz LENGTH _____ins

BORN AT _____ DR WHO DELIVERED_____

FATHERS NAME _____DOB _____ SS# ____-____-____
LAST FIRST MI

MOTHERS NAME _____ DOB _____ SS# ____-____-____
LAST FIRST MI

MAILING ADDRESS _____ PHONE ( ) _____
STREET/PO BOX CITY STATE ZIP

FATHER'S EMPLOYER _____ PHONE ( ) _____

BUSINESS ADDRESS _____

MOTHER'S EMPLOYER _____ PHONE ( ) _____

BUSINESS ADDRESS _____

PATIENT INSURANCE_____
(PLEASE PROVIDE COPY OF INSURANCE CARD; SEE BOTTOM OF PAGE)

PATIENT SIBLINGS (list additional children on back if necessary)

_____ _____
NAME D.O.B. NAME D.O.B

_____ _____
NAME D.O.B NAME D.O.B

RELATIVE OR FRIEND WE MAY CONTACT IN AN EMERGENCY:
_____ PHONE ( ) _____

_____
ADDRESS

IS THE PATIENT ALLERGIC TO ANY MEDICATION? YES_____ NO_____ DON'T KNOW_____

IF YES, NAME OF MEDICATION_____

E-MAIL ADDRESS _____

SIGNATURE OF PERSON RESPONSIBLE _____

PLEASE PRESENT THIS INFORMATION SHEET WHEN COMPLETED TO THE BOOKKEEPING DESK WHERE A COPY WILL BE MADE OF YOUR INSURANCE CARD IF YOU HAVE INSURANCE FOR WHICH WE ARE A PROVIDER OR WHICH WE MAY BILL

PLEASE REMEMBER THAT PAYMENT IS YOUR OBLIGATION REGARDLESS OF INSURANCE OR OTHER THIRD PARTY INVOLVEMENT

INFORMACION DE PACIANTE

Fecha de Hoy _____ Numero de Seguro _____-_____-_____ Sexo ___F ___M

Nombre de paciente _____ Fecha de nacimiento _____
Apellido primer Segundo

Lugar de Nacimiento _____ Doctor _____ Peso _____

Nombre de Padre _____ D.O.B. _____ SS# _____-_____-_____
Apellido Primer feche de nacimiento numero de seguro

Nombre de Madre _____ D.O.B. _____ SS# _____-_____-_____
Apellido Primer feche de nacimiento numero de seguro

Domicilio _____ numero de telefono _____
Calle primer nombre cuidad estados zona postal

Empleo de Padre _____ telefono de trabajo _____

Domicilio de trabajo _____

Empleo de Madre _____ telefono de trabajo _____

Domicilio de trabajo _____

Aseguranza del paciente _____

Hermanos o hermanas

_____ _____
Nombre fecha de nacimiento Nombre feche de nacimiento

_____ _____
Nombre feche de nacimiento Nombre feche de nacimiento

Un amigo o pariente en caso de emergencia

_____ _____
Nombre Domicilio Telefono

El paciente es allergico/a a medicinas? Si___ No___ Yo no se ___ _____
Nombre de Medicina

Firma de persona responsable de pago _____

Por favor presente esta informacion. Presente su tarjeta de aseguranza medica le tomaremos una copia.
Por favor recuerde que el pago es su obligacion.

Stanford
Children's Health

Pediatric Group of Monterey
1900 Garden Rd. Suite 110
Monterey, CA 93940

AUTHORIZATION TO TREAT A MINOR

I), We), the undersigned parent(s) of _____ a minor, do hereby authorize the following people to bring this child into this medical facility for the undersigned to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon whether such diagnosis or treatment is rendered at the Pediatric Group of Monterey.

1. _____
2. _____
3. _____
4. _____

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power in the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his (her) best judgment may deem advisable. It is also understood that every effort shall be made by the above named agent(s) to contact the undersigned prior to rendering emergency treatment to the patient.

This authorization shall remain effective for one year from the date of execution or unless sooner revoked in writing delivered to said agent(s).

Date of Authorization: _____

Parent(s) or Legal Guardian: _____ (Name) _____ (Signature)

Stanford Children's Health | Lucile Packard Children's Hospital Stanford

Lucile Packard Children's Hospital
STANFORD UNIVERSITY MEDICAL CENTER
725 Welch Road Palo Alto, CA 94304

CONSENT ◦ MYCHART PROXY ACCESS REQUEST

Addressograph or Label

MyChart Proxy Access Request Form- *Request for Online Access to Medical Records*

I hereby request Lucille Packard Children's Hospital Stanford/Stanford Children's Health provide access to health information in MyChart allowable by law, of the minor patient named below to the following proxy representative.

Please note the following age range limitations for MyChart. These age range limitations do not affect any legal right you have to access your child's records by other means. To request a copy of your child's record, contact the medical records department.

- If your child is age 0-11: You will be granted full access to your child's MyChart record, a subset of complete medical records
- If your child is age 12-17: You will be granted partial access to your child's MyChart record. (e.g. immunizations, messaging)
- Once your child reaches age 18, you will no longer have access to your child's MyChart record.

Please print legibly and complete all fields to ensure timely processing.

MEDICAL RECORD ACCESS REQUEST

Patient Name:		My relationship to patient:	Are you the legal custodian*?
_____ First	_____ Last	❑Parent ❑Other	❑Yes ❑No
Date of Birth: _____	MRN: _____	_____	

*Legal documents may be required, such as a birth certificate, guardianship papers, adoption documents, etc.

REQUESTOR INFORMATION (Parent/Legal Guardian)

Your Name: _____ First _____ Last

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Date of Birth: _____

Email: _____

Your Signature: _____ Date: _____

FACILITY USE ONLY

Date Received:	Patient Relationship Verified By: _____ Name _____ Phone Number
Proxy MRN:	**Proxy Access Approved:** ❑Yes ❑No **Letter Sent:** ❑Yes ❑No Date Sent: _____ ❑**Form FAXED to HIMS for processing**

Stanford Children's Health

Pediatric Group of Monterey

1900 Garden Rd, Suite 110
Monterey, CA 93940
Tel (831) 372-5841
Fax (831) 372-4820

REQUEST FOR RELEASE OF MEDICAL RECORDS

Date: _____

Please send the following information on:

Patient's Name: _____ (LAST NAME), _____ (FIRST NAME) _____ (MI) **Date of Birth** ____/____/__ (MM/DD/Y)

Information Needed:
- ☐ Shot Records
- ☐ Chart Notes
- ☐ Laboratory Data
- ☐ Discharge Summaries
- ☐ X-Ray Reports
- ☐ Other: _____

Select one of the following:
- ☐ Mail to Doctor
- ☐ Mail to Self
- ☐ Will pick-up
- ☐ Email:

_____ @ _____ . ____

Please send records to:

_____
_____
_____
_____

I am requesting records be sent from:

_____
_____
_____
_____

Purpose of Disclosure:
- ☐ Continued Medical Care
- ☐ Payment of Insurance Claims
- ☐ Personal
- ☐ Legal
- ☐ Other: _____

Parent/Guardian: _____ (PRINT NAME) **Parent/Guardian Signature:** _____