



**SUTTER HEALTH USE ONLY**

MRN:  
DOB:  
Doc Type:  
DOS:

**Proxy Access Form (Children Under 18)**

**Select Your Sutter Affiliate / Hospital**

- Sutter Medical Foundation       Sutter East Bay Medical Foundation       Sutter Gould Medical Foundation
- Palo Alto Medical Foundation       Sutter Pacific Medical Foundation
- Sutter Community Connect (write provider's name): MARY ANN ELLIS JAMMAL M.D
- A Sutter Hospital (write hospital name): ALL

**Request for Online Access to Medical Records for a Minor Child**

I hereby request that the Sutter Health affiliate provides access to the health information in My Health Online allowable by law, of the patient named below to the following individual. For stepparents, please complete the "Written Authorization for a Stepparent to Access the Medical Record of a Minor Child" form found on this website. Please complete all fields and print legibly to ensure timely processing.

**Patient Name:** \_\_\_\_\_  
(Under Age 18) Last First MI

**Phone:** (\_\_\_\_) \_\_\_\_\_ **SSN:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
Last 4 Digits Only MM/DD/YYYY

**Proxy Representative:** \_\_\_\_\_  
Please Print Legibly

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **ZIP Code:** \_\_\_\_\_

**Phone:** (\_\_\_\_) \_\_\_\_\_ **SSN:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
Last 4 Digits Only MM/DD/YYYY

**Email:** \_\_\_\_\_

**Relationship to child\*:**  Parent  Guardian  Conservator

\*Legal documents may be required, e.g., marriage certificate, birth certificate, guardianship papers, power of attorney.

**Proxy Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Fax to:** (877) 607-6484      **or**      **Mail to:** Patient Services Contact Center  
P.O. Box 255386  
ATTN: My Health Online Proxy  
Sacramento, CA 95865-5386

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MRN: \_\_\_\_\_ Department / Care Center: \_\_\_\_\_  
Patient ID Verified By: \_\_\_\_\_ Physician Name: \_\_\_\_\_