

Medical Record Number

Patient Name

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**

Addressograph or Label - Patient Name, Medical Record Number

**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 ***