

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 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 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 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 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 ***