



My Health Online Release of Information Request

SUTTER HEALTH USE ONLY

MRN:
DOB:
Doc Type:
DOS:

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): _____
- A Sutter Hospital (write hospital name): _____

My Health Online provides you confidential, secure access to your personal health information – anywhere you have internet access. With My Health Online, you can conveniently access health information, view test results, request appointments, and more. For more information: Visit your local Sutter Health Affiliate's website or www.SutterHealth.org, E-mail us at myhealthonline@sutterhealth.org, or call us at 1-866-978-8837.

I request Sutter Health to release my personal health information, including test results, to my online personal health record. I understand that medical providers are prohibited by California law from releasing certain test results electronically. I understand that access to my health information is for my use only.

SIGNATURE: _____ DATE: _____

Enrollment Information

- You must be 18 or older to enroll.
- Your Online ID and password should not be shared with anyone.

Receiving Your Access Code

Your access code will be mailed to you. Please allow up to one week for processing.

Requester Information

Please ensure you sign this form. A missing signature will delay processing your request.

Name _____
(please print legibly)

Bring this form to your next medical appointment or fax or mail your completed form to the Patient Services Contact Center

Today's Date ____ / ____ / ____

Date of Birth (MM/DD/YYYY) ____ / ____ / ____

E-mail _____

Mailing Address _____

City _____ State _____ ZIP _____

Phone (_____) _____

Fax: Patient Services Contact Center
Attn: My Health Online, (877) 607-6484

Mail: Patient Services Contact Center
Attn: My Health Online
P.O. Box 255386
Sacramento, CA 95865-5386

If you would like a copy for your records, please photocopy this form.

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Patient ID/Signature Verified By: _____ Date: ____ / ____ / ____