|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  | **AUTHORIZATION FOR USE AND** | | | | | | | | | | | |  |
|  |  |  |  |  |  | **DISCLOSURE OF HEALTH INFORMATION** | | | | | | | | | | | | | |  |
| Patient Name: | | | |  |  |  |  | DOB: | | | | | |  | MRN: | | | | |  |
| Address: | |  |  |  |  | City: | |  |  |  |  | State: | |  |  |  | Zip: | |  |  |
| Phone: | |  | |  |  |  |  | | |  | |  |  |  |  |  |  |  |  |  |
|  | | Email (optional): | | | | | | | | | |  |  |  |  |  |  |  |
|  |  | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Type of Access Requested: | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| [ ] Paper Copy [ ] CD [ | | | | ] My Health Online | | | | [ ] Inspection Only | | | | | | [ ] Email (encrypted) | | | | | |  |



* ] Email (**not** encrypted) (*Note: If you would like us to send information over email* *not* *encrypted, this increases the risk that information could be read by an unauthorized third party).* [ ] Other (must be agreed upon by patient and provider): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Delivery Method Requested: [ ] Mail [ ] Email [ ] Fax [ ] Pick-Up (If applicable)

[ ] My Health Online Portal

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Purpose of Requested Use or Disclosure: | | | | | |  |  |  |  |  |  |  |
| [ | ] Continuity of Care – Appointment Date with Physician: | | | | | / | / | |  |  |  |  |
| [ | ] Patient | [ ] Insurance | [ ] Other: | |  |  |  |  |  |  |  |  |
| **Authorization** | |  |  |  |  |  |  |  |  |  |  |  |
| I hereby authorize: | | |  |  |  |  |  |  |  |  |  |  |
|  |  |  | |  |  | | |  |  |  |  |  |
|  |  | (Name of hospital, physician, healthcare provider) | | | | | | | |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Address |  |  | City | |  |  |  | State | Zip |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | Phone |  |  |  |  |  |  | Fax | **OR** |  |  |
| To release my health information to: [ ] Self (same address as above), | | | | | | | | | |  |  |

(Name of individual, organization, medical provider)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | Address | |  | City | State | | Zip | |
|  |  |  |  |  |  |  | |  |  |
|  |  |  | Phone |  |  | Fax | |  |  |
|  | **Information to be disclosed:** | | |  |  |  |  |  |  |
| [ | | ] Complete Medical Record | | [ | ] History and Physical | [ | ] Laboratory Test(s) | | |
| [ | | ] Outpatient Clinic Records | | [ | ] Consultation | [ | ] Radiology Report(s) | | |
| [ | | ] Pertinent Information | | [ | ] Operative Report | [ | ] Radiology Images: | | |
|  |  | (Hospital Only) | | [ | ] Discharge Summary |  | [ | ] X-ray | |
| [ | | ] Home Health and | | [ | ] Emergency |  | [ | ] Ultrasound | |
|  |  | Hospice Record | |  | Physician Report |  | [ | ] CT [ ] MRI | |
| [ | | ] Other: |  |  |  |  | [ | ] Mammography | |

**Specify date(s) of service for records requested**:



10/7/2015

**I specifically authorize release of the following information**:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| [ | ] HIV test results | | | (initial) | [ | ] Substance abuse | | | (initial) |
| [ | ] Mental Health | |  | (initial) | [ | ] Genetic testing | |  | (initial) |
|  |  |  |  |  |  |  |  |  |  |

**EXPIRATION:** This authorization shall become effective immediately and shall remain ineffect for one year from the date signed unless a different date is specified here:

**RESTRICTIONS:** California law prohibits the recipient from making further disclosure ofyour health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

**YOUR RIGHTS:**

* I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.
* I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to this address:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **For Sutter Hospitals:** | **Palo Alto** | **Sutter East Bay Medical** | **Sutter Gould Medical** | **Sutter Pacific Medical** | **Sutter Medical** |
| Sutter Shared Services | **Medical Foundation** | **Foundation** | **Foundation** | **Foundation** | **Foundation** |
| Attn: HIM Director PO | Attn: HIM Director 795 | Attn: HIM Director 3687 ML | Attn: HIM Director 600 | Attn: HIM Director 3700 | Attn: HIM Director 1014 N. |
| Box 619091 Roseville, | El Camino Real Palo | Diablo Blvd #200 Lafayette, | Coffee Road Modesto, | California St #1570 San | Market Blvd #10 |
| CA 95661 | Alto, CA 94301 | CA 94549 | CA 95350 | Francisco, CA 94118 | Sacramento, CA 95834 |

* My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
* I have a right to receive a copy of this authorization (required if authorization is requested for the provider’s use or disclosure of health information).
* I may inspect and obtain a copy of the health information of which I am authorizing the use or disclosure.

If this box [ ] is checked the facility listed above will receive compensation for the use or disclosure of my health information.

SIGNATURE: Date: Time:

(Patient/Legal Representative)

If signed by other than patient, print name and relationship:

Name: Relationship:

**There may be fees incurred for this service.**

**Office Use Only** Identification verified by (name):

Verified by (method): [ ] Photo ID [ ] Matching Signature [ ] Other

10/7/2015