See attached instructions for help with completing this form

Sutter Health

PATIENT LABEL

# AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION



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

## Patient Information (*Tell us about the patient*)

Patient Name: _____ DOB: _____ MRN: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email (optional): _____

## Type of Access Requested (*Please check ONLY one*)

☐ 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 the patient and provider): _____

## Delivery Method (*Please check ONLY one*)

☐ Mail ☐ Email ☐ Fax ☐ Pick-Up (if applicable) ☐ My Health Online Portal

## Purpose of Requested Use or Disclosure (*Tell us how you will use the records*)

☐ Continuity of Care – Appointment Date with Physician: _____

☐ Patient ☐ Insurance ☐ Other: _____

## Authorization – I hereby authorize: (*Click dropdown or use attached list to select your Sutter care facility)*

_____

(Name of hospital, physician, healthcare provider)

_____

Address City State Zip

_____

Phone Fax

## To release my health information to: ☐ Check this box if same as patient listed above. *OR*

_____

(Name of hospital, physician, healthcare provider, other)

_____

Address City State Zip

_____

Phone Fax

## Information Disclosure (*Tell us what information you need*)

**Information to be disclosed for the following date range** _____ **to** _____:

☐ Hospital Records (Inpatient and Outpatient)

☐ Clinic/Foundation Records (Specify Provider Name): _____

☐ Radiology Report(s) Only

☐ Radiology Images (Specify): ☐ X-ray ☐ Ultrasound ☐ CT scan ☐ MRI ☐ Mammography

☐ Laboratory Test(s) Only

☐ Other: _____

Sutter Health

# AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION



**Please mail or fax a copy of this Authorization form to the address or fax number shown on the attached address list for the Sutter Health affiliate where you received care. Complete one Authorization for each affiliate if you received care at more than one location. Thank You.**

## Special Authorization (*Tell us if we have permission to release the following sensitive information)*

**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 in effect for one (1) year from the date signed unless a different date is specified here: _____

## Restrictions

California law prohibits the recipient from making further disclosure of your 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 Medical Foundation** | **Sutter East Bay Medical Foundation** | **Sutter Gould Medical Foundation** | **Sutter Pacific Medical Foundation** | **Sutter Medical Foundation** |
|---|---|---|---|---|---|
| Sutter Shared Services | Attn: HIM Director | Attn: HIM Director | Attn: HIM Director | Attn: HIM Director | Attn: HIM Director |
| Attn: HIM Director | 795 El Camino Real | 3687 Mt Diablo Blvd. #200 | 600 Coffee Road | 3883 Airway Dr. Suite 320 | 1014 N. Market Blvd. #10 |
| P.O. Box 619091 | Palo Alto, CA 94301 | Lafayette, CA 94549 | Modesto, CA 95350 | Santa Rosa, CA 95403 | Sacramento, CA 95834 |
| Roseville, CA 95661 | | | | | |

- My revocation will be effective upon receipt, but will have no impact on uses or disclosure made while my authorization was valid.
- I have a right to receipt 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 of my health information.

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

## Signature (*As required by law*) ***Please print and manually sign. We do not accept e-signature at this time.***

SIGNATURE: _____ Date: _____ Time: _____
(Patient/Legal Representative)

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

Name: _____ Relationship: _____

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

Verified by (method): ☐ Photo ID ☐ Matching Signature ☐ Other: _____

# Release Form Instructions

(Note: Use Adobe Reader to type directly on the form or print and complete manually)

## *How to Complete Page 1:*

- Patient Information:
  - Patient Name: Type or print the patient's first and last name.
  - DOB: Type or print the patient's date of birth.
  - MRN: Type or print the medical record number (if known), otherwise leave blank.
  - Address, City, State, Zip, Phone and e-Mail: Give us your complete address including phone number and e-Mail address.
- Type of Access Requested. Tell us how you want us to create your records (on paper, on CD, e-Mail (encrypted), e-Mail (non-encrypted), or My Health Online). Please check ONLY one.
- Delivery Method. Tell us how you want us to send your information (by mail, by e-Mail, by Fax, by My Health Online Portal, or pick-up). If by e-Mail, we will sent it encrypted to protect your privacy unless you tell us otherwise. If "pick-up", you must arrange to pick up your records at the local Health Information Management department at the facility where you received treatment. Please check ONLY one.
- Purpose of Requested Use or Disclosure. Tell us how you will use the records. This is required by law. Check your selection.
- Authorization (I hereby authorize). Click on the dropdown to select the name of the Sutter affiliate where you received care or manually enter from the attached facility list. If you received treatment at a Sutter Clinic/Foundation, please give us the name of your physician. These will be the records we will release.
- To release my health information to. Tell us to whom we should release the records. If for yourself, check the box "Check this box if same as patient listed above."
- Information Disclosure. Tell us the date range when you received your care and which records you want released to you. Check the appropriate box that applies to you.
  - *Hospital Records (Inpatient and Outpatient)* - Select only if you received care at one of our hospitals. Information release to you may include discharge summary, history and physical reports, consult notes, test results, operative and procedure reports, pathology results, and other relevant clinical information.
  - *Clinic Foundation Records* – Select only if you want records from your doctor's office visit. Please give us the name of your provider to expedite your request. Information released to you may include office notes, physical exam notes, and other relevant clinical information.
  - *Radiology Reports* – Select only if you want a copy of your recent x-ray test results.
  - *Radiology Images* – Select only if you want film copy on CD of your x-ray tests.
  - *Laboratory Test(s)* – Select only if you want a copy of your recent lab results.
  - *Billing Records* – Select only only if you want a copy of your itemized detail bill.
  - *Other* – Tell us what other types of records you may need.

Copy fees may apply as allowed by law. If fees apply, we will contact you prior to releasing records.

*How to Complete Page 2*:

- Special Authorization. Tell us if we have permission to release special types of records that are protected separately by law (if they apply). Please check and initial all that apply.
- Expiration. Enter a specific date for when you want this authorization to expire. If not specified, the form will be good one year from the date of receipt.
- Restrictions. For your information only.
- Your Rights. For your information only.
- Signature, Date and Time (As required by law). The patient or patient representative must sign, date and time the form. If you are not the patient, enter your name and relationship to the patient. We do not accept electronic signatures at this time.

Note: For your protection, it is requested, but not required, that you include a legible copy of a photo ID with the Request form for identity verification purposes.

## Sutter Health Affiliate Listing (Hospitals and Foundations/Clinics) for Requesting Medical Record Copies

| Facility Name | Address | City | State | Zip | HIM Dept # | Fax # |
|---|---|---|---|---|---|---|
| Alta Bates Comprehensive Cancer Center | 2001 Dwight Way | Berkeley | CA | 94704 | (510) 204-5091 | (510) 204-2043 |
| Alta Bates Summit Medical Center - Ashby Campus | 2450 Ashby Ave - Room 1140 | Berkeley | CA | 94705 | (510) 204-1446 | (510) 841-8818 |
| Alta Bates Summit Medical Center - Herrick Campus | 2001 Dwight Way | Berkeley | CA | 94704 | (510) 204-1446 | (510) 841-8818 |
| Alta Bates Summit Medical Center - Merritt Campus | 350 Hawthorne Ave | Oakland | CA | 94609 | (510) 869-6545 | (510) 655-8114 |
| Alta Bates Summit Medical Center - Providence Campus | 3100 Summit St | Oakland | CA | 94609 | (510) 869-6545 | (510) 655-8114 |
| California Pacific Medical Center - California Campus | 3700 California St - Ste 1570 | San Francisco | CA | 94118 | (855) 398-1633 | (916) 736-5499 |
| California Pacific Medical Center - Davies Campus | 45 Castro at Duboce St | San Francisco | CA | 94114 | (855) 398-1633 | (916) 736-5499 |
| California Pacific Medical Center - Pacific Campus / Buchanan St. | 2333 Buchanan St | San Francisco | CA | 94115 | (855) 398-1633 | (916) 736-5499 |
| California Pacific Medical Center - Pacific Campus / Clay St. | 2351 Clay St | San Francisco | CA | 94115 | (855) 398-1633 | (916) 736-5499 |
| California Pacific Medical Center - Pacific Campus / Diamond St | 115 Diamond St | San Francisco | CA | 94114 | (855) 398-1633 | (916) 736-5499 |
| California Pacific Medical Center - Pacific Campus / Sutter St. | 1375 Sutter St | San Francisco | CA | 94109 | (855) 398-1633 | (916) 736-5499 |
| California Pacific Medical Center Transplant Program | 2340 Clay St | San Francisco | CA | 94115 | (855) 398-1633 | (916) 736-5499 |
| Dorothy Schneider Cancer Center (Mills Peninsula) | 100 S. Mateo Dr | San Mateo | CA | 94401 | (855) 398-1633 | (916) 736-5499 |
| Eden Medical Center Outpatient Rehab Services | 14207 14th St | San Leandro | CA | 94578 | (855) 398-1633 | (916) 736-5499 |
| Eden Medical Center | 20103 Lake Chabot Rd | Castro Valley | CA | 94546 | (855) 398-1633 | (916) 736-5499 |
| Kalmanowitz Child Development Center (San Rafael) | 4000 Civic Center Dr - Ste 210 | San Rafael | CA | 94903 | (855) 398-1633 | (916) 736-5499 |
| Kalmanowitz Child Development Center (SanFrancisco) | 1580 Valencia St - Ste 440 | San Francisco | CA | 94110 | (855) 398-1633 | (916) 736-5499 |
| Lafayette Women's Health | 3595 Mt. Diablo Blvd | Lafayette | CA | 94549 | (510) 204-1446 | (510) 841-8818 |
| Memorial Hospital Los Banos | 520 I Street | Los Banos | CA | 93635 | (855) 398-1633 | (916) 736-5499 |
| Memorial Medical Center | 1700 Coffee Rd | Modesto | CA | 95355 | (855) 398-1633 | (916) 736-5499 |
| Menlo Park Surgical Hospital | 570 Willow Rd | Menlo Park | CA | 94025 | (855) 398-1633 | (916) 736-5499 |
| Mills Peninsula Medical Center (El Camino Real) | 1783 El Camino Real | Burlingame | CA | 94010 | (855) 398-1633 | (916) 736-5499 |
| Mills Peninsula Medical Center | 1501 Trousdale Drive | Burlingame | CA | 94010 | (855) 398-1633 | (916) 736-5499 |
| Novato Community Hospital | 180 Rowland Way | Novato | CA | 94945 | (855) 398-1633 | (916) 736-5499 |
| Novato Community Hospital: Physical Therapy & Sports Fitness (Novato) | 100 Rowland Way | Novato | CA | 94945 | (855) 398-1633 | (916) 736-5499 |
| Novato Community Hospital: Physical Therapy & Sports Fitness (San Rafael) | 4000 Civic Center Dr - Ste 214 | San Rafael | CA | 94903 | (855) 398-1633 | (916) 736-5499 |
| Palo Alto Medical Foundation - Camino Division | 701 E. El Camino Real | Mountain View | CA | 94040 | (408) 523-3267 | (408) 524-5034 |
| Palo Alto Medical Foundation - Mills Division | 701 E. El Camino Real | Mountain View | CA | 94040 | (408) 523-3267 | (408) 524-5034 |
| Palo Alto Medical Foundation - Palo Alto & Alameda Divisions | 795 El Camino Real | Palo Alto | CA | 94301 | (650) 853-4745 | (650) 838-1606 |
| Palo Alto Medical Foundation - Santa Cruz Division | 2880 Soquel Ave - Ste 1 | Santa Cruz | CA | 95062 | (831) 458-5520 | (831) 479-6636 |
| San Mateo Hand Therapy Clinic | 101 N. El Camino Real #1 | San Mateo | CA | 94401 | (855) 398-1633 | (916) 736-5499 |
| California Pacific Medical Center - Mission Bernal Campus | 3555 Cesar Chavez St | San Francisco | CA | 94110 | (415) 641-6515 | (415) 641-6735 |
| Sutter Amador Hospital | 200 Mission Blvd | Jackson | CA | 95642 | (855) 398-1633 | (916) 736-5499 |
| Sutter Auburn Faith Hospital | 11815 Education St | Auburn | CA | 95602 | (855) 398-1633 | (916) 736-5499 |
| Sutter Center for Psychiatry | 7700 Folsom Blvd | Sacramento | CA | 95826 | (855) 398-1633 | (916) 736-5499 |
| Sutter Coast Community Clinic | 780 East Washington Blvd - Ste 202 | Crescent City | CA | 95531 | (855) 398-1633 | (916) 736-5499 |
| Sutter Coast Health Center | 555 5th St - Ste 2 | Brookings | OR | 97415 | (855) 398-1633 | (916) 736-5499 |
| Sutter Coast Hospital | 800 East Washington Blvd | Crescent City | CA | 95531 | (855) 398-1633 | (916) 736-5499 |
| Sutter Coast Rural Health & Urgent Care | 780 East Washington Blvd - Ste 202 | Crescent City | CA | 95531 | (855) 398-1633 | (916) 736-5499 |
| Sutter Coast Walk-In Clinic | | Crescent City | CA | 95531 | (855) 398-1633 | (916) 736-5499 |
| Sutter Davis Hospital | 2000 Sutter Place | Davis | CA | 95616 | (855) 398-1633 | (916) 736-5499 |
| Sutter Delta Medical Center | 3901 Lone Tree Way | Antioch | CA | 94509 | (925) 779-3039 | (925) 779-3009 |
| Sutter East Bay Medical Foundation | 3687 Mt. Diablo Blvd - Ste 200 | Lafayette | CA | 94549 | (510) 204-6695 | (510) 549-9319 |
| Sutter Gould Medical Foundation - Modesto | 600 Coffee Rd | Modesto | CA | 95350 | (209) 524-1211 | (209) 526-7146 |
| Sutter Gould Medical Foundation - Stockton | 2505 W. Hammer Lane | Stockton | CA | 95209 | (209) 956-1552 | (209) 473-9388 |
| Sutter Health Rural Health Clinic (Los Banos) | 1253 I Street | Los Banos | CA | 93635 | (855) 398-1633 | (916) 736-5499 |
| Sutter Lakeside Community Clinic | 5196 Hill Road East - Ste 300 | Lakeport | CA | 95453 | (855) 398-1633 | (916) 736-5499 |
| Sutter Lakeside Family Medicine Clinic | 5176 Hill Road East | Lakeport | CA | 95453 | (855) 398-1633 | (916) 736-5499 |
| Sutter Lakeside Hospital | 5176 Hill Road East | Lakeport | CA | 95463 | (855) 398-1633 | (916) 736-5499 |
| Sutter Maternity & Surgery Center Santa Cruz | 2900 Chanticleer Ave | Santa Cruz | CA | 95065 | (855) 398-1633 | (916) 736-5499 |
| Sutter Medical Center Sacramento | 2825 Capitol Ave | Sacramento | CA | 95816 | (855) 398-1633 | (916) 736-5499 |
| Sutter Medical Foundation (Sac/Placer/Yuba/Yolo/Solano) | 1014 N. Market Blvd #20 | Sacramento | CA | 95834 | (855) 421-3530 | (855) 421-9633 |
| Sutter Pacific Medical Foundation | 3883 Airway Dr - Ste 210 | Santa Rosa | CA | 95403 | (707) 521-8990 | (707) 573-5407 |
| Sutter Roseville Medical Center | One Medical Plaza | Roseville | CA | 95661 | (855) 398-1633 | (916) 736-5499 |
| Sutter Santa Rosa Bariatric Clinic | 4729A Hoen Ave | Santa Rosa | CA | 95405 | (707) 576-4235 | (707) 541-9107 |
| Sutter Santa Rosa Regional Hospital | 30 Mark West Springs Rd | Santa Rosa | CA | 95404 | (707) 576-4215 | (707) 541-9107 |
| Sutter Solano Medical Center | 300 Hospital Dr | Vallejo | CA | 94589 | (916) 298-2208 | (707) 554-5110 |
| Sutter Tracy Community Hospital | 1420 N. Tracy Blvd | Tracy | CA | 95376 | (855) 398-1633 | (916) 736-5499 |
| Whitney Clinic | 1625 Van Ness St. - 3rd Floor | San Francisco | CA | 94109 | (855) 398-1633 | (916) 736-5499 |