



Sutter Medical Foundation

A Sutter Health Affiliate

- Sutter Medical Group
- Sutter West Medical Group
- Sutter Neuroscience Medical Group, Inc.

Office Use Only

NC \_\_\_\_\_

App. \_\_\_\_\_

Scan Date \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

X Patient Name: \_\_\_\_\_ DOB X \_\_\_\_\_ MR# \_\_\_\_\_

X Type of Access Requested:  Copies  Inspection  Verbal Consent

**Authorization**

I hereby authorize \_\_\_\_\_  
name of hospital, physician, health care provider

\_\_\_\_\_ address \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip

X to use and/or disclose my health information.

to: \_\_\_\_\_  
name of individual, organization, etc.

\_\_\_\_\_ address \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip

X Purpose of disclosing information: \_\_\_\_\_

This authorization applies to the following information: \_\_\_\_\_

Provide only the following records or types of records (provide treatment dates):

	Date		Date
<input type="checkbox"/> H&P		<input type="checkbox"/> Special Tests	
X <input type="checkbox"/> Discharge Summary		<input type="checkbox"/> Lab/X-ray	
<input type="checkbox"/> Consultation		<input type="checkbox"/> ER Records	
<input type="checkbox"/> Outpatient Records		<input type="checkbox"/> Other	

**OR**

X All of my records from (enter dates) \_\_\_\_\_  
(Note: HIV test results require a special authorization)

I understand that the information in my health record may include information relating to sexually transmitted disease, or acquired immunodeficiency syndrome (AIDS). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

**Expiration**

This authorization will expire on (enter date or event) \_\_\_\_\_ or six months from the date of execution.

## California 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, payment or health plan enrollment or eligibility for benefits.
- I may revoke this authorization at anytime. My revocation must be in writing, signed by me or on my behalf, and delivered to Health Information Services Department at this facility.
- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.

## Redisclosure

I understand that if the recipient of my information is not a healthcare provider, a health plan or healthcare clearing house, or not an entity required to comply with federal or state health privacy regulations, my health information may be further disclosed by such recipient and my information may no longer be protected by state and federal laws.

I have a right to receive a copy of this authorization.

If this box  is checked, a copy was requested and received. Initials \_\_\_\_\_

Phone #: Day X \_\_\_\_\_ Message \_\_\_\_\_

Patient Signature X \_\_\_\_\_ Date X \_\_\_\_\_

Personal Representative Signature \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Witness \_\_\_\_\_

## Is there a charge for release of health information?

Yes, the copy services will charge you a fee. Please request the name and number of the copy service used by the care center.

**ATTENTION RECIPIENT: ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSE OF THIS DISCLOSURE.**