Sutter Health
Sutter Medical Foundation
We Plus You

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 or USB Drive [ ] Inspection Only [ ] Email (encrypted)
[ ] Other (must be agreed upon by patient and provider): _____
(Note: If you would like us to send information over email unencrypted, this increases the risk that the information could be read by an unauthorized third party.)

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

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

To release my health information to: [ ] Self (same address as above), **OR**

_____
(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 (Hospital Only)	[ ] Operative Report	[ ] Radiology Images:
	[ ] Discharge Summary	[ ] X-ray
[ ] Home Health and Hospice Records	[ ] Emergency Physician Report	[ ] Ultrasound
		[ ] CT [ ] MRI
[ ] Other: _____		[ ] Mammography

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

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 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:

Sutter Medical Foundation
Attn: HIPAA Privacy Officer
1014 N. Market Blvd., Suite 10, 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 _____

Mail or Fax Completed Form to: 1014 N. Market Blvd., Suite 20, Sacramento, CA 95834
Fax #: 1-855-421-9633

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