Sutter Health
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 [ ] 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

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
[ ] Outpatient Clinic Records
[ ] Pertinent Information (Hospital Only)
[ ] Home Health and Hospice Record
[ ] Other:_____

[ ] History and Physical
[ ] Consultation
[ ] Operative Report
[ ] Discharge Summary
[ ] Emergency Physician Report

[ ] Laboratory Test(s)
[ ] Radiology Report(s)
[ ] Radiology Images:
[ ] X-ray
[ ] Ultrasound
[ ] CT [ ] MRI
[ ] 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:

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 PO Box 619091 Roseville, CA 95661	Attn: HIM Director 795 El Camino Real Palo Alto, CA 94301	Attn: HIM Director 3687 ML Diablo Blvd #200 Lafayette, CA 94549	Attn: HIM Director 600 Coffee Road Modesto, CA 95350	Attn: HIM Director 3700 California St #1570 San Francisco, CA 94118	Attn: HIM Director 1014 N. Market Blvd #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 _____

Release Form Instructions

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

How to Complete Page 1:

- **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 (not encrypted), or My Health Online).
- **Delivery Method**: Tell us how you want us to send you the information (by mail, by e-Mail, by Fax, by My Health Online Portal, or pick-up). If by e-Mail, we will send 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. Check your selection.
- **Purpose of Requested Use or Disclosure**: Tell us why you need the records. (This is required by law). Check your selection.
- **Authorization**: Click the dropdown to select the name of the Sutter affiliate where you received care or manually enter from attached facility list. If you received treatment at a Sutter Foundation, please give us the name of your physician. These will be the records we will release. Tell us to whom we should release the records. If you want these records for yourself only, mark the box **"Self."** If you are sending these to another person or health care provider, give us the name and address where you want the records mailed.
- **Information to be disclosed**: Tell us which records you want released to you. If billing records only, please check "Other" and write in "detailed billing records." Copy fees may apply as allowed by law. If fees apply, we will contact you prior to releasing records.

- **Specify date(s) of service for records requested**: Tell us the specific treatment dates of service for the records you are requesting. For example: January 2015 to the present.

How to Complete Page 2:

- **I specifically authorize release of the following information**: 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 for one year from date of receipt.
- **Restrictions**: For your information only.
- **Your Rights**: For your information only.
- **Signature, Date and Time**: 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 ROI request 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) 655-4000	(510) 655-8114
California Pacific Medical Center - California Campus	3700 California St - Ste 1570	San Francisco	CA	94118	(415) 600-6246	(415) 600-2113
Eden Medical Center	20103 Lake Chabot Rd	Castro Valley	CA	94546	(510) 727-3065	(510) 888-9198
Memorial Hospital Los Banos	520 I Street	Los Banos	CA	93635	(209) 826-0591	(209) 827-0102
Memorial Medical Center	1700 Coffee Rd	Modesto	CA	95355	(209) 572-7252	(209) 569-7333
Menlo Park Surgical Hospital	570 Willow Rd	Menlo Park	CA	94025	(650) 324-8500	(650) 289-9034
Mills-Peninsula Health Services	1501 Trousdale Drive	Burlingame	CA	94010	(650) 696-5595	(650) 696-7828
Novato Community Hospital	180 Rowland Way	Novato	CA	94945	(415) 209-1454	(415) 209-1451
Palo Alto Medical Foundation - Camino Division	MS 10-306 - 701 E. El Camino Real	Mountain View	CA	94040	(408) 523-3267	(408) 524-5034
Palo Alto Medical Foundation - Mills Division	MS 10-306 - 701 E. El Camino Real	Mountain View	CA	94041	(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) 853-6093
Palo Alto Medical Foundation - Santa Cruz Division	2880 Soquel Ave - Ste 1	Santa Cruz	CA	95062	(831) 458-5520	(831) 479-6636
St. Luke's Hospital	3555 Cesar Chavez St	San Francisco	CA	94110	(415) 641-6515	(415) 641-6735
Sutter Amador Hospital	200 Mission Blvd	Jackson	CA	95642	(209) 223-4713	(209) 223-7585
Sutter Auburn Faith Hospital	11815 Education St	Auburn	CA	95602	(530) 888-4510	(530) 888-4592
Sutter Center for Psychiatry	7700 Folsom Blvd	Sacramento	CA	95826	(916) 386-3603	(916) 386-3075
Sutter Coast Hospital	800 East Washington Blvd	Crescent City	CA	95531	(707) 464-8665	(707) 464-8877
Sutter Davis Hospital	2000 Sutter Place	Davis	CA	95616	(530) 757-5106	(530) 757-5127
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) 521-1211	(209) 526-7146
Sutter Gould Medical Foundation - Stockton	2505 W. Hammer Lane	Stockton	CA	95209	(209) 956-1552	(209) 473-9388
Sutter Lakeside Hospital	5176 Hill Road East	Lakeport	CA	95463	(707) 262-5060	(707) 262-5173
Sutter Maternity & Surgery Center Santa Cruz	2900 Chanticleer Ave	Santa Cruz	CA	95065	(831) 477-2207	(831) 477-2209
Sutter Medical Center Sacramento	2825 Capitol Ave	Sacramento	CA	95816	(916) 887-1030	(916) 887-1035
Sutter Medical Foundation	1014 N. Market Blvd #20	Sacramento	CA	95834	(855) 421-3530	(855) 421-9633
Sutter Pacific Medical Foundation - North Bay	3883 Airway Dr - Ste 320	Santa Rosa	CA	95403	(707) 521-8990	(707) 573-5407
Sutter Pacific Medical Foundation - South Bay	3883 Airway Dr - Ste 320	Santa Rosa	CA	95403	(707) 521-8990	(707) 573-5407
Sutter Roseville Medical Center	One Medical Plaza	Roseville	CA	95661	(916) 781-1074	(916) 781-1553
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	(707) 554-5070	(707) 554-5110
Sutter Tracy Community Hospital	1420 N. Tracy Blvd	Tracy	CA	95376	(209) 832-6058	(209) 832-6043
Sutter Shared Services	PO Box 619091	Roseville	Ca	95661	(916) 297-9034	(916) 736-5499