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

Patient Name: _____ DOB _____ MR# _____

Address: _____ State _____ Zip _____

Type of Access Requested: ❑ Copies ❑ Inspection ❑ Verbal Consent

Authorization

I hereby authorize _____
name of hospital, physician, health care provider

_____
address city state zip

to use and/or disclose my health information.

to: _____
name of individual, organization, etc.

_____
address city state zip

Purpose of disclosing information:

❑ Transfering primary care providers

This authorization applies to the following information: _____

_____

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

	Date		Date
❑ H&P		❑ Special Tests	
❑ Discharge Summary		❑ Lab/X-ray	
❑ Consultation		❑ ER Records	
❑ Outpatient Records		❑ Other	

OR

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 Department (medical records) at your clinicians office.
- 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 _____ Message _____

Patient Signature _____ Date _____

Personal Representative Signature _____

Relationship to Patient _____

Witness _____

Is there a charge for release of health information?

Yes, the copy service will be charging 25 cents per page for photo copy and 50 cents per page for microfilm. In addition you will be charged for tax and postage if mailed. 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.