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:
[X] 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 [X] Fax [ ] Pick-Up (If applicable)
[ ] My Health Online Portal

Purpose of Requested Use or Disclosure:
[ ] Continuity of Care – Appointment Date with Physician:____/___/_____
[ ] Patient [ ] Insurance [X] Other: Life Insurance

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**

Hoosier Services Inc.
(Name of individual, organization, medical provider)

18032 Lemon Drive, Suite C-618 Yorba Linda CA 92886
Address City State Zip

(800) 882-4156 (800) 882-4957
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	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	3700 California St #1570	1014 N. Market Blvd #10
PO Box 619091	Palo Alto, CA 94301	Lafayette, CA 94549	Modesto, CA 95350	San Francisco, CA 94118	Sacramento, CA 95834
Roseville, CA 95661					

- 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 _____

Please mail or fax a copy of this Authorization form to the address or fax number selected from the drop down list on the reverse side of this form.