Medical Record Authorization Form Instructions

March 2021

►Important: Please download and save a copy of this form before filling it out.◄

How to Complete the Medical Record Authorization Form

- **Are you the patient?**
  - Answer "**Yes**" if you are the patient or "**No**" if you are the patient's legal or personal representative.
    - **NOTE**: If you answer "No, I am the patient's legal/personal representative", you may be asked to provide supporting documentation that gives you the authority to request medical records on the behalf of the patient.
- **Patient Information**
  - Enter the patient's First and Last Name, Middle Initial (if any), date of birth, full address, phone number, and the patient's email address (required for contact purposes)
- **Who do you want to request records from?**
  - Enter the name of the Sutter Health facility or Sutter doctor's full name, address, phone number and fax number.
- **Where do you want the records sent to?**
  - Check the box if you want records sent to the patient only.
    You can then skip to the next section if the recipient's information is the same as the Patient Information.
  - If records will be sent to someone other than the patient, enter the recipient's full name, address, city, state, zip code, recipient phone number, recipient fax or email.
- **What is the reason for requesting records?**
  - Choose the appropriate reason for requesting records. **Check only one (1)**.
- **What treatment dates of service are you looking for?**
  - List the approximate date range for the treatment dates of service you need to the best of your ability.
- **What types of records would you like? (Check all that apply).**
  - **Clinic/Doctor's Office Visit Notes – ALL Providers**:
    Select only if you want notes from any physician the patient may have seen.
  - **Following Specific Providers(s) ONLY**: Select only if you want notes from a specific doctor's visit.
    Please give us the name of the treating provider to expedite your request.
  - **Hospital Records**:
    Select only if you want records from inpatient hospitalizations or emergency room visits at one of our hospitals.
  - **Immunizations**: Select only if you want immunization/vaccination records (e.g. flu shots, DTAP, etc.).
  - **Lab Test Results**: Select only if you want lab test results (e.g. urinalysis, CBC, etc.).
  - **Radiology Reports (CT, MRI, X-ray, etc.)**: Select only if you want a copy of radiology exam results (printed form).
    NOTE: To request radiology images, visit https://www.sutterhealth.org/for-patients/request-medical-record and click on the appropriate link.
  - **Operative Reports/Procedure Notes**:
    Select only if you want a copy of the operative report or procedure note of the patient's surgeries or procedures.
  - **Physical/Occupational/Speech Therapy Records**:
    Select only if you want copy of physical therapy, occupational therapy, or speech therapy records.
  - **Home Health Records (Sutter Care At Home)**: Select only if you want records related to visits by home health caregivers through *Sutter Care at Home (SCAH)* or *Sutter Visiting Nurses Association & Hospice (SVNAH)*.
  - **Other**: Select only if you are seeking records not listed above. You can provide specific details in the next section.

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- **Please describe the specific records you're requesting to help us respond more completely to your request. (Example: Related to a condition or surgery, specific lab tests, all available records, etc.).**
  - This section is optional. Enter additional details as desired related to the types of records you need.
- **Do we have permission to release the following protected information that may be contained in your medical records?**
  - Please check all that apply. Leave blank if none of them apply to the requested records.
- **Is there a deadline for this request?**
  - Answer **"Yes, I have a deadline."** if you have a deadline and specify the date you need the records
  - Answer "**No, just as soon as possible.**" if you don't have a specific deadline.
    - **NOTE**: California law allows healthcare providers up to 15 days to fulfill your request.
- **How would you like us to send the records? **Must select one (1) option ONLY***
  - Tell us how you would like to receive the records. **Check only one (1) option from the list.**
- **Expiration Date (Optional)**. The authorization will be effective for one (1) year from the date you sign it unless you specify otherwise. You have the right to give us an alternative expiration date. However, if you do, it must be dated at least 15 days in the future from Today's date to allow ample time to process your request as permitted by California law.
- **Your Rights Under the Law**. This section is informational only. It explains your rights under state and federal privacy laws.
- **Signature and Date**. A signature and date are required for the authorization to be valid.
  If you are completing the authorization on behalf of the patient, also print your name and your relationship to the patient.

Additional Requirements:

- Photo ID: Must include a legible copy of your photo ID or other government-issued ID along with the authorization form for identity verification purposes. If picking up the records in-person, you will be asked to provide your photo ID at that time.
- If you are someone other than the patient: In addition to a Photo ID, please include a copy of valid supporting documentation that gives you authority to request records on behalf of the patient. (Exception: Parents of minor patients).
  Acceptable forms of supporting documentation include:
  - *Advanced Healthcare Directive* (must be in effect at time of requesting records)
  - *Death Certificate*
  - *Executor of the Estate* (for deceased patients only)
  - *Power of Attorney* (must include a provision that allows medical decision-making and/or release of medical records)
  - *Power of Attorney for Health Care* (must include a provision that allows release of medical records)
  - or some other form of documentation (subject to final review)

Thank you for selecting Sutter Health as your provider of choice.

Sutter Health

PATIENT LABEL

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Are you the Patient?

☐ Yes ☐ No, I'm the patient's legal/personal representative*

**Note: If you're not the patient, you may be asked to provide supporting documentation to verify that you are authorized to make this request on behalf of the patient.*

Patient Information

Patient Name:		Date of Birth:	
Address, City, State, ZIP:			
Patient Phone:		Email:	

Who do you want to request records from?

Healthcare Provider or Facility Name:	
Address, City, State, ZIP:	
Phone:	Fax:

Where do you want the records sent to? *Note: We can release information only to who you authorize.*

☐ **Check this box if records are being sent to the patient only. No further action in this section needed.**

Recipient Name:			
Recipient Address, City, State, ZIP:			
Recipient Phone:		Recipient Fax or Email:	

What is the reason for requesting records?

☐ I'm moving and/or switching doctors ☐ Getting a second opinion ☐ Seeing a Specialist
☐ Military Enlistment ☐ Personal Use ☐ Other reason: _____

What treatment dates of service are you looking for?

Specify an approximate* date range – Start: ____/____/____ to End: ____/____/____

**Date range doesn't have to be exact. Enter dates to the best of your ability.*

What types of records would you like? *Note: Some records may only be available on paper or PDF.*

☐ Clinic/Doctor's Office Visit Notes – ALL Providers ***OR*** ☐ Following Specific Provider(s) ONLY:

_____

☐ Hospital Records ☐ Immunizations ☐ Lab Test Results ☐ Radiology Reports (CT, MRI, X-ray, etc.)
☐ Operative Reports/Procedure Notes ☐ Physical/Occupational/Speech Therapy Records
☐ Home Health Records (Sutter Care at Home) ☐ Other (Please specify)

Please describe the specific records you're requesting to help us respond more completely to your request. (Example: related to a condition or surgery, specific lab tests, all available records, etc.)

Do we have permission to release the following protected information* that may be contained in your records? Please check all that apply below. **Additional authorization may be required.*

☐ HIV Test Results ☐ Substance Use/Drug Abuse Records
☐ Mental Health Records ☐ Genetic Testing Results

Sutter Health

PATIENT LABEL

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Is there a deadline for this request?

By law we have up to 15 days to fulfill your request. However, if you have an urgent need for an upcoming appointment, please let us know. We will do our best to honor your deadline.

☐ Yes, I have a deadline. Date needed: _____ ☐ No, just as soon as possible.

How would you like us to release the records? *Must select one (1) option ONLY*

☐ Patient Portal (My Health Online) ☐ Email (encrypted) ☐ Email (unencrypted)*

☐ Fax (50-page limit) ☐ CD (encrypted) by Mail ☐ CD (encrypted) by In-Person Pickup

Per Page Fees May Apply: ☐ Paper by Mail ☐ Paper by In-Person Pickup

For Additional Fee: ☐ USB flash drive (encrypted) by Mail ☐ USB flash drive (encrypted) by In-Person Pickup

**Sending information by unencrypted email increases the risk of being read by an unauthorized third party.*

Expiration Date

This authorization shall become effective immediately and remain in effect for one (1) year from the date signed below unless specified here*: _____

**Optional Expiration Date (must be at least 15 days in the future from Today's date to be valid)*

Your Rights Under the Law

- 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 mailed to this address:
  - Sutter Shared Services, Attn: Release of Information, P.O. Box 619091, 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 the right to receive a copy of this authorization.
- I may inspect and obtain copy of my health information for which I am authorizing the use or disclosure for as long as the information is maintained by the affiliate(s) listed above.
- The location(s) listed above will not receive compensation for the use or disclosure of my health information.
- I understand that California law prohibits the recipients of my health information from making further disclosure of my health information unless the recipient obtains another authorization from me or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

SIGNATURE AND DATE *(As required by law)*

SIGNATURE: _____ Date: _____ Time: _____

(Patient or Legal/Personal Representative*)

*If signed by someone other than the patient, print name and specify relationship to the patient:

Name: _____ Relationship: _____

NOTE: To request **Billing Records** or **Radiology Images,** visit https://www.sutterhealth.org/for-patients/request-medical-record and click on the appropriate link.

Sutter Health Facility Listing (Hospitals and Clinics/Foundations) for Requesting Medical Record Copies

Facility Name	Mailing Address	City	State	Zip	Fax	Email
Alta Bates Comprehensive Cancer Center, **Berkeley**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Alta Bates Summit Medical Center – Ashby & Herrick Campuses, **Berkeley**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Alta Bates Summit Medical Center – Summit / Merritt / Providence Campuses, **Oakland**	350 Hawthorne Ave	Oakland	CA	94609	(510) 655-8114	absmc-summithimroiteam@sutterhealth.org
California Pacific Medical Center – California / Davies / Pacific / Van Ness Campuses, **San Francisco**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
California Pacific Medical Center – St. Luke's / Mission Bernal Campus, **San Francisco**	3555 Cesar Chavez Street	San Francisco	CA	94110	(415) 641-7595	WBMBHIM@sutterhealth.org
California Pacific Medical Center: Transplant Program, **San Francisco**	PO Box 619091	Roseville	CA	95661	(916) 736-5435	S3AMBROIDept@sutterhealth.org
California Pacific Medical Center: Whitney Clinic, **San Francisco**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Eden Medical Center Outpatient Rehabilitation Services**, San Leandro**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Eden Medical Center, **Castro Valley**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Kalmanowitz Child Development Center, **San Francisco/San Rafael**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Lafayette Women's Health, **Lafayette**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Los Banos Rural Health Clinic, **Los Banos**	PO Box 619091	Roseville	CA	95661	(916) 736-5449	S3ROIDept@sutterhealth.org
Memorial Hospital Los Banos, **Los Banos**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Memorial Medical Center, **Modesto**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Menlo Park Surgical Hospital, **Menlo Park**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Mills Peninsula Medical Center, **Burlingame**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Mills Health Center, **San Mateo**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Mission Bernal **Clinics/Doctor's Offices, San Francisco**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Novato Community Hospital, **Novato**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Novato Community Hospital: Physical Therapy & Sports Fitness, **Novato**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	PAMFROIDept@sutterhealth.org
Palo Alto Medical Foundation (PAMF) **Clinics/Doctor's Offices – Camino & Mills Division**	63 Encina Ave	Palo Alto	CA	94301	(650) 942-8354	PAMFROIDept@sutterhealth.org
Palo Alto Medical Foundation (PAMF) **Clinics/Doctor's Offices – Palo Alto & Alameda Divisions**	63 Encina Ave	Palo Alto	CA	94301	(650) 838-1606	PAMFROIDept@sutterhealth.org
Palo Alto Medical Foundation (PAMF) **Clinics/Doctor's Offices – Santa Cruz Division**	2751 Research Park Drive	Santa Cruz	CA	95073	(831) 479-6636	PAMFSZROIDept@sutterhealth.org
San Mateo Hand Therapy Clinic, **San Mate**o	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Sutter Amador Hospital, **Jackson**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Sutter Auburn Faith Hospital, **Auburn**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Sutter Care At Home (SCAH) / Sutter Visiting Nurses Association & Hospice (SVNAH), **Multiple Locations**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Sutter Center for Psychiatry, **Sacramento**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Sutter Coast **Clinics/Doctor's Offices, Crescent City**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Sutter Coast Health Center, **Brookings OR**	PO Box 619091	Roseville	OR	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Sutter Coast Hospital, **Crescent City**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org

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Facility Name	Mailing Address	City	State	Zip	Fax	Email
Sutter Davis Hospital, **Davis**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Sutter Delta Medical Center, **Antioch**	3901 Lone Tree Way	Antioch	CA	94509	(925) 779-3009	sdmc-himreleaseofinformation@sutterhealth.org
Sutter East Bay Medical Foundation (SEBMF) **Clinics/Doctor's Offices, Albany / Antioch / Berkeley / Brentwood / Castro Valley / Oakland / Orinda**	PO Box 619091	Roseville	CA	95661	(916) 736-5435	S3AMBROIDept@sutterhealth.org
Sutter Gould Medical Foundation (SGMF) **Clinics/Doctor's Offices, Ceres / Manteca / Modesto / Patterson / Turlock**	PO Box 619091	Roseville	CA	95661	(916) 736-5435	S3AMBROIDept@sutterhealth.org
Sutter Gould Medical Foundation (SGMF) **Clinics/Doctor's Offices, Lodi / Stockton / Tracy**	PO Box 619091	Roseville	CA	95661	(916) 736-5435	S3AMBROIDept@sutterhealth.org
Sutter Lakeside **Clinics/Doctor's Offices, Lakeport**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Sutter Lakeside Hospital, **Lakeport**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Sutter Maternity & Surgery Center Santa Cruz, **Santa Cruz**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Sutter Medical Center Sacramento (Sutter General/Memorial Hospital), **Sacramento**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Sutter Medical Foundation (SMF) **Clinics/Doctor's Offices, Davis / West Sacramento / Winters / Woodland**	PO Box 619091	Roseville	CA	95661	(916) 736-5435	S3AMBROIDept@sutterhealth.org
Sutter Medical Foundation (SMF) **Clinics/Doctor's Offices, Citrus Heights / Elk Grove / Folsom / Rancho Cordova / Sacramento**	PO Box 619091	Roseville	CA	95661	(916) 736-5435	S3AMBROIDept@sutterhealth.org
Sutter Medical Foundation (North) - **Clinics/Doctor's Offices, Brownsville / Yuba City**	PO Box 619091	Roseville	CA	95661	(916) 736-5435	S3AMBROIDept@sutterhealth.org
Sutter Pacific Medical Foundation (SPMF) **Clinics/Doctor's Offices, Healdsburg / Novato / Petaluma / Rohnert Park / San Francisco / Santa Rosa**	PO Box 619091	Roseville	CA	95661	(916) 736-5435	S3AMBROIDept@sutterhealth.org
Sutter Roseville Medical Center, **Roseville**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Sutter Santa Rosa Infusion Center, **Santa Rosa**	PO Box 619091	Roseville	CA	95661	(707) 541-9107	S3ROIDept@sutterhealth.org
Healthy Steps Bariatric and Metabolic Center, **Santa Rosa**	PO Box 619091	Roseville	CA	95661	(707) 541-9107	S3ROIDept@sutterhealth.org
Sutter Santa Rosa Regional Hospital, **Santa Rosa**	PO Box 619091	Roseville	CA	95661	(707) 541-9107	S3ROIDept@sutterhealth.org
Sutter Solano Medical Center, **Vallejo**	300 Hospital Drive	Vallejo	CA	94589	(707) 554-5110	SSMCHIMROITeam@sutterhealth.org
Sutter Medical Foundation (West) - **Clinics/Doctor's Offices, Dixon / Fairfield / Vacaville / Vallejo**	PO Box 619091	Roseville	CA	95661	(916) 736-5435	S3AMBROIDept@sutterhealth.org
Sutter Tracy Community Hospital, **Tracy**	PO Box 619091	Roseville	CA	95661	(916) 736-5499	S3ROIDept@sutterhealth.org
Sutter Walk-In Care Clinics – Bay Area, **Aptos / Concord / Dublin / Milpitas / Mountain View / Novato / Oakland / Petaluma / San Francisco / San Jose / San Ramon / Santa Clara / Santa Rosa / Walnut Creek**	63 Encina Ave	Palo Alto	CA	94301	(650) 838-1606	PAMFROIDept@sutterhealth.org
Sutter Walk-Care Clinics – Valley Area, **Citrus Heights / Davis / El Dorado Hills / Elk Grove / Folsom / Natomas / Rancho Cordova / Roseville / Sacramento / Vacaville / West Sacramento**	PO Box 619091	Roseville	CA	95661	(916) 736-5435	S3AMBROIDept@sutterhealth.org
Transplant Outreach Clinics, **Multiple Locations**	PO Box 619091	Roseville	CA	95661	(916) 736-5435	S3AMBROIDept@sutterhealth.org