Sutter Health

ROI form for adult patients age 18 and over

PATIENT LABEL

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

There may be fees incurred for this service.

Patient Information (*Tell us about the patient*)

Patient Name: _____ DOB: _____ MRN: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email (optional): _____

Type of Access Requested (*Please check ONLY one*)

☐ 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 the patient and provider): PDF from AllScripts or Diversified Medical Records

Delivery Method (*Please check ONLY one*)

☐ Mail ☐ Email ☐ Fax ☐ Pick-Up (if applicable) ☐ My Health Online Portal

Purpose of Requested Use or Disclosure (*Tell us how you will use the records*)

☒ Continuity of Care – Appointment Date with Physician: _____/_____/_____

☐ Patient ☐ Insurance ☐ Other: _____

Authorization – I hereby authorize:

Lawrence Shore, M.D.

(Name of hospital, physician, healthcare provider)

Address City State Zip

Phone Fax

To release my health information to: ☐ Check this box if same as patient listed above. *OR*

Sutter Pacific Medical Foundation c/o Lawrence Shore, M.D.

(Name of hospital, physician, healthcare provider, other)

1375 Sutter Street, Suite 308 San Francisco CA 94109

Address City State Zip

(415) 369-1362

Phone Fax

Information Disclosure (*Tell us what information you need*)

Information to be disclosed for the following date range _____ to _____:

☒ Hospital Records (Inpatient and Outpatient)

☒ Clinic/Foundation Records (Specify Provider Name): Lawrence Shore, M.D.

☐ Radiology Report(s) Only

☐ Radiology Images (Specify): ☐ X-ray ☐ Ultrasound ☐ CT scan ☐ MRI ☐ Mammography

☐ Laboratory Test(s) Only

☐ Billing Records ☒ Other: Face sheet, meds, past 2 yrs clinic notes, hosp recs, 1 yr labs

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Special Authorization (*Tell us if we have permission to release the following sensitive information)*

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 (1) 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	Sutter East Bay	Sutter Gould	Sutter Pacific	Sutter Medical
	Medical Foundation	Medical Foundation	Medical Foundation	Medical Foundation	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	3883 Airway Dr. Suite 320	1014 N. Market Blvd. #10
P.O. Box 619091	Palo Alto, CA 94301	Lafayette, CA 94549	Modesto, CA 95350	Santa Rosa, CA 95403	Sacramento, CA 95834
Roseville, CA 95661					

- My revocation will be effective upon receipt, but will have no impact on uses or disclosure made while my authorization was valid.
- I have a right to receipt 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 of my health information.

If this box ☐ is checked, the facility listed above will receive compensation for the use or disclosure of my health information.

Signature *(As required by law)* ***Please sign and date below. No e-signature accepted.***

SIGNATURE: _____ Date: _____ Time: _____

(Patient/Legal Representative)

If signed by other than the patient, print name and relationship:

Name: _____ Relationship: _____

Office Use Only Identification verified by (name): _____

Verified by (method): ☐ Photo ID ☐ Matching Signature ☐ Other: _____