Aurora
Santa Rosa Hospital

Medical Records Requests and Pick Up hours are from 9:00 am – 4:00 pm Ph. #: 707-800-7761

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

(Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this Authorization Request.)

Patient Name _____ **Date of Birth** _____

I hereby authorize **AURORA Santa Rosa Hospital 1287 Fulton Road, Santa Rosa, CA 94501**

Phone: 707-800-7761 Fax: 707-800-7798 to release to or to allow:

☐ Patient Patient's Address_____City_____

State_____ Zip_____ Phone_____ Fax_____

☐ Other _____Phone _____

(Name of Facility or person)

Address _____ City_____ State_____ Zip_____

a. ☐ Inspection of medical records (*by appointment only with the presence of a clinical staff*)

b. ☐ Copies of the following information: ☐ Psychiatric Evaluation ☐ History & Physical

☐ Discharge Summary ☐ Labs ☐ Other _____

Date of Service_____

c. I specifically authorize release of the following information (check as appropriate):

☐ HIV test results_____(initial) ☐ Mental health treatment information _____ (initial)

☐ Alcohol/drug treatment _____ (initial)

I wish to pick up medical records (please check here) ☐

I wish to have the medical records mailed (please check here) ☐

I wish to have the medical records faxed to my physician (please check here) ☐ *Fax #*_____

PURPOSE

☐ Continuing care ☐ Personal ☐ Legal proceedings ☐ Other_____

MY RIGHTS

I may revoke this Authorization at any time, but I must do so in writing to Aurora Santa Rosa Hospital. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization and if not earlier revoked it shall terminate one (1) year from the date of signing.

AUTHORIZATION TO RELEASE MEDICAL/PSYCHIATRIC INFORMATION
AURORA SANTA ROSA HOSPITAL
1287 Fulton Road, Santa Rosa, CA 95401

ASRH2016

Patient Identification:

I have the right to receive a copy of this Authorization.
Cost for copying of the record: First copy complementary, thereafter, $.25 per page.
Please make check payable to Aurora Santa Rosa Hospital. NO CASH PLEASE.

_____ _____
SIGNATURE of Patient/Conservator/Legal Guardian/Beneficiary * **Date**

*Witness of Above Signature*_____

_____ _____
SIGNATURE of Parent if a minor **Date**

*Witness of Above Signature*_____

**Please furnish a copy of your conservator/guardianship papers or death certificate if beneficiary.*

PHYSICIAN RESPONSE

Doctor, please check the appropriate box, sign and return to Medical Records immediately.

☐ The patient may have the requested Medical Records ☐ The patient may inspect the record
☐ I will prepare a summary ☐ Request denied Reason for denial _____

Physician Signature _____ Date_____

Under California law, a health care provider may decline to permit inspection or provide copies of mental health records only if the provider determines there is a substantial risk of significant adverse or detrimental consequences to a patient in seeing or receiving a copy of her/his mental health records. If request is denied, the patient has a right to designate a licensed psychiatrist/ psychologist/ licensed marriage and family therapist or a licensed clinical social worker who may inspect or have a copy of the records.

For official use only: (do not fill out)

Records released:

☐ Discharge Summary
☐ Psychiatric Evaluation
☐ H & P
☐ Progress Notes
☐ Labs/X-ray/other diagnostic tests results
☐ Other: _____
_____
_____
_____

AUTHORIZATION TO RELEASE MEDICAL/PSYCHIATRIC INFORMATION
AURORA SANTA ROSA HOSPITAL
1287 Fulton Road, Santa Rosa, CA 95401

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Patient Identification: