



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

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Patient's Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

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:

Name and Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
(Name of facility or person)  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

- 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  Lab  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

Patient Identification:

I have the right to receive a copy of this Authorization.

Cost for copying of the record: First copy complimentary, 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**

**Patient Identification:**