Palo Alto Medical Foundation
Sutter Health

AUTHORIZATION FOR USE AND DISCLOSURE OF DIAGNOSTIC MEDICAL IMAGES AND REPORTS

Completion of this document authorizes the disclosure and/or use of identifiable health information, as set forth below, consistent with California and federal law concerning the privacy of such information. Failure to provide all information requested, including the pre-payment processing fee might invalidate or delay the processing of this Authorization. Patient will be contacted when the request has been processed.

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION AND MEDICAL IMAGES

This authorization for use or disclosure of medical images is required by state and federal law. MR #________________

Patient's Name: ________________ ________ DOB:____________

Last *First* *MI*

Daytime Telephone Number________________ Social Security No:________________

I HEREBY AUTHORIZE THE USE AND DISCLOSURE OF THE ABOVE HEALTH INFORMATION AND RELEASE OF MEDICAL IMAGES FOR MYSELF OR FOR A MINOR FOR WHICH I AM THE GUARDIAN

Organization releasing information. Choose the location based on the location of your doctor. If your doctor is in:

Cupertino, Los Gatos, Mountain View, Santa Clara and Sunnyvale	**Dublin, Fremont, Los Altos, Menlo Park, Palo Alto, Portola Valley and Redwood City**	**Aptos, Capitola, Santa Cruz, Scotts Valley, Soquel and Watsonville**
Mail or FAX Form to:		
❑ **Diagnostic Imaging Request** 701 E. El Camino Real Mountain View, CA 94040 Phone: 650-934-7757 Fax: 650-934-7790	❑ **Diagnostic Imaging Request** 795 El Camino Real Palo Alto, CA 94301 Phone: 650-853-4876 Fax: 650-853-6090	❑ **Diagnostic Imaging Request** 2025 Soquel Avenue Santa Cruz, CA 95062 Phone: 831-458-5521 Fax: 831-423-0716

I authorize ________________ to pick up the requested items below on my behalf.

Patient's Guardian - Printed Name ________________ Relationship to Patient____________

Patient/Patient's Guardian - Signature________________ Date________

RELEASE THE ABOVE HEALTH INFORMATION AND MEDICAL IMAGES TO

(NAME OF PERSON OR ORGANIZATION RECEIVING INFORMATION)

STREET ADDRESS CITY STATE ZIP CODE

THIS AUTHORIZATION APPLIES TO THE SELECTED IMAGE CATEGORIES. Prior to requesting medical images, please verify the media type with your physician. Indicating incorrect media types may incur additional fees.

All requests will be processed within 1–2 business days. Urgent/stat requests will be processed based on volume and availability
Cds are not protected and are the patient's responsibility to safeguard. **Please indicate specific study types and the dates.**

CDs are $10 each and FILMs are $10.00 per sheet

Exam Type			Exam Date(s)
☐ Mammograms	Films ONLY- No Charge		
☐ X-rays ________ ________	☐ CD	☐ FILM	________ ________
☐ MRI	☐ CD	☐ FILM	
☐ CT	☐ CD	☐ FILM	
☐ Ultrasound	☐ CD	☐ FILM	
☐ Nuclear Medicine Scans	☐ CD	☐ FILM	

Requested Items will be: ☐ Mailed ☐ Picked Up

** Requested items that are not picked up within 60 days of request will require a new submission. **

Staff use only: ☐ Personal use ☐ Continued Care ☐ Paid