Santa Rosa Community Health
Permission to Release Medical Records

Patient Name	Phone	Date of birth
Patient Address, City, State & ZIP		

What medical records do you want to release?

☐ My complete medical records (last two years)
☐ Only records from (date):_____to (date):_____
☐ Only records for a specific type of care (like x-rays, lab tests,etc.):

_____

☐ A medical summary of my care

Do you want your records to include information about these conditions?

• AIDS or infection with HIV	☐ Release	☐ Do not release
• Mental health treatment/psychotherapy notes	☐ Release	☐ Do not release
• Treatment for alcohol and/or drug abuse	☐ Release	☐ Do not release

Reason for release? ☐ Patient is transferring care ☐ Other reason:_____

☐ Release records TO Santa Rosa Community Health

Release information **FROM** this doctor/facility:

Name:_____

Address:_____

City/State/ZIP:_____Phone:_____

Please send this information to:

☐ **URGENT – PLEASE FAX: 707-303-3094**

☐ **Send/Deliver to Medical Records** (mail, drop off, fax)

☐ Release records FROM Santa Rosa Community Health

Release information **TO** this doctor/facility:

Name:_____

Address:_____

City/State/ZIP:_____Phone:_____

SRCH Medical Records Department
1110 N. Dutton Avenue Santa Rosa, CA 95401
Phone: 707-236-6909 | Fax: 707-303-3094

Sign below to give your permission

I authorize my information to be released for the purpose of my care. This release is good for one year. I understand I can revoke this authorization in writing any time, except when information has already been released. I understand I have a right to a copy of this authorization. I understand that my health information may not be used or shared in other ways unless I give another authorization, or unless that use is specifically allowed by law. The facility, its employees, officers, and doctors are released from any legal liability for disclosing my health information to the extent they are authorized.

☐ **I want this authorization to expire on this date, or when this event happens:**_____

Signed _____ Date: _____ Relationship to patient _____

Patient Name: _____ **DOB:** _____

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Process for Requesting Records

- ✓ Fill out Release of Information Form **correctly** and **entirely**
  - Incomplete release form is invalid and will delay the process

- ✓ Show ID

- ✓ We legally have **15 working days to** complete your request.
  - Begins once release is filled out correctly and entirely

- ✓ Make sure to initial the "Release Information" or "Do not release information" confidential boxes, near the middle of the page.

- ✓ If you are requesting records for yourself, there is a $15 fee (for records over 15 pages)
  - Records under 15 pages are free
  - If you make multiple requests, over a period of time, for the same information, there will be a charge of $1 per page, or $15.
  - There is a $15 fee for sending records to an attorney

- ✓ If you need records sent to another doctor or medical facility, there is no fee for faxing/mailing records

- ✓ Methods of release include, paper copy, media, or to patient's MyChart portal, patients can sign up by going to https://srhealth.org/epic-live/mychart

- ✓ Copies of immunizations and physical are free

- ✓ A printout of your Medical Summary is free

- ✓ If requesting copies of **mental health records** from your Psychiatrist/Psychologist, your request will need to be sent to the mental health provider for approval. You should first talk to your Psychiatrist/Psychologist about getting copies of your records, to speed up the process

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