Sutter Health

How to request radiology images

Use these instructions to complete the Radiology Images Authorization Form (SH-0122)

Patient information

Enter the patient's first and last name, middle initial (if applicable), address, date of birth and phone number, including area code. An email address is optional.

Sutter Health location releasing images

Enter the name of the Sutter Health location where the images were taken. Scan the QR code below if you need help finding the correct imaging center.

How would you like your images delivered? (Images are available on CD only.)

- **Send them by mail to:** Check this box and provide the name and mailing address where the CD should be sent.
- **I will pick them up myself:** Check this box if you plan to pick up the CD in person. The imaging department will contact you when it's ready.
- **I authorize the following person to pick them up for me:** Check this box and provide the first and last name of the person authorized to pick up the CD on your behalf.

What would you like released?

Select the type(s) of images you're requesting, such as CT scan, MRI, X-ray, ultrasound or mammography. Select all that apply. If you select Other, specify the exam type.

Purpose of disclosure

Provide the reason you're requesting the records. This information is required by law.

Expiration date (optional)

Unless otherwise specified, this authorization expires one year from the date it's signed. You may choose a different expiration date, but it must be at least 15 days after the signature date to allow time for processing as permitted by California law.

Signature and date

Sign and date the form. Both are required for the authorization to be valid. This section also explains your rights under the law.

If signed by other than the patient

Print your name and relationship to the patient. If you're signing on the patient's behalf, you may be required to provide documentation showing your legal authority to request records.

Examples include:

- Advance Health Care Directive (must be in effect when records are requested)
- Death certificate
- Executor of the estate documentation (for deceased patients only)
- Power of attorney that authorizes medical decision-making and/or release of medical records
- Other supporting documentation, subject to review

Sutter Health

PATIENT LABEL

AUTHORIZATION FOR RELEASE OF RADIOLOGY IMAGES

Patient Information

Name:

Address, City, State, ZIP:

Date of Birth: Phone:

Sutter Health Location Releasing Images

Sutter Health Location Name:

How Would You Like Your Images Delivered? (Note: Images are produced on CD only)

☐ Send them by mail to:
Name:
Address:
City, State, ZIP:

☐ I will pick them up myself

☐ I authorize the following person to pick them up for me (first and last name):

What Would You Like Released?

☐ CT Scan ☐ MRI ☐ X-ray ☐ Ultrasound ☐ Mammography ☐ Other _____

☐ Images covering period of time: ____/____/____ to ____/____/____ ☐ All dates of treatment

Purpose of Disclosure

☐ Personal Use ☐ Transfer of Care ☐ Second Opinion ☐ Seeing a Specialist ☐ Other

Expiration Date

This authorization shall become effective immediately and shall remain in effect for one (1) year from the date signed unless otherwise specified here: _____

Signature and Date *(As required by law)*

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, in writing, signed by me or on my behalf, and mailed to this address: Sutter Shared Services, Attn: Release of Information, PO Box 619091, Roseville, CA 95661. My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid. I have the right to receive a copy of this authorization. I may inspect and obtain copy of my health information for which I am authorizing for as long as the information is maintained by the affiliate(s) listed above. The location(s) listed above will not receive compensation for the use or disclosure of my health information. I understand that California law prohibits the recipients of my health information from making further disclosure of my health information unless the recipient obtains another authorization from me or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

SIGNATURE: _____ Date: _____ Time: _____
(Patient/Legal Representative)

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

Name: _____ Relationship*: _____

*Must provide legal documentation (e.g., Power of Attorney)

PRINT RESET