SHARP

Health Information Management (HIM) Department
Mailing Address: 5651 Copley Center Dr. Suite A. San Diego, CA 92111
Phone: 858-541-5400 Fax: 858-636-2287 Email: SHC.Records@sharp.com

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

All sections must be complete before Sharp HealthCare may disclose your PHI.

EXPLANATION: This form authorizes the use or disclosure of PHI in the manner described below and is voluntary. Refusal to sign will not affect your ability to obtain treatment from Sharp HealthCare. Please be aware that once your information leaves Sharp HealthCare, we will no longer be able to protect that information, and the recipients of your information may not be legally required to protect your information.

AUTHORIZATION TO DISCLOSE SPECIFIC PHI: Federal and State laws require us to obtain specific authorization from patients to release especially sensitive information. Sensitive information is defined as treatment or documentation related to Human Immunodeficiency Virus (HIV) and AIDS test results; psychiatric care, and treatment for alcohol or drug abuse. Be aware that we will automatically exclude these types of information unless you specifically identify them for release.

RECEIVING RECORDS ELECTRONICALLY: If you prefer this option, provide an email address where directed and select whether you would like to receive the records encrypted or unencrypted. If you choose unencrypted, you understand that there is some risk that identifiable health information and other confidential information may be misdirected, read, or intercepted by unauthorized parties.

RESTRICTIONS: I understand that Sharp HealthCare may not further use or disclose the information described on page 2 of this form unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I hereby release Sharp HealthCare from any/all liability that may arise from the release of this information to the party named on this form.

ADDITIONAL COPY: I understand that I have a right to receive a copy of this authorization upon request.

REVOCATION: I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken.

CHARGES: You may be responsible for payment of a reasonable, cost-based processing fee. The fee covers clerical costs as well as any/all costs associated with copying of the information.

OUTSIDE RECORDS: I understand it is the practice of Sharp HealthCare hospitals to retain all records received from outside providers. I further understand it is not the practice for Sharp Rees-Stealy to retain all outside medical records. If Sharp Rees-Stealy physicians choose not to maintain copies of your medical records from physicians outside of Sharp Rees-Stealy, you will need to contact your non-Sharp HealthCare provider for complete copies of those records.

NOTICE TO OCCUPATIONAL MEDICINE PATIENTS: California law allows your employer to access your health records only if you authorize the disclosure in writing, or for certain specific reasons. Some of the reasons include situations when your employer is required to do so by law; when you're involved in a lawsuit (or similar process) with your employer and your medical history is at issue; when the information was requested or paid for by your employer; when the information is required to evaluate your need for medical leave or disability related benefits; or when it is necessary to administer your employee benefits plan. If you have questions or concerns about whether any of the above situations applies to you, please notify your provider before beginning any procedure and consider notifying your employer.

SHC-MR-3794-NS

Patient Name: _____

Date of Birth: _____

Medical Record Number: _____

Label

PRINT SAVE AS EMAIL RESET

SHARP

OFFICE USE			
SHC#:	User ID/Facility:	Date:	☐ ID Checked
Completed by:	Date:	DOS Released:	Total Pages:
Documents Released/Comments:			

Patient Name:		**Birthdate:**		**Phone:**	

Obtain Records From (*check all that apply*):

☐ **Sharp Rees-Stealy Medical Center**

☐ **Sharp Hospital**: ☐ Chula Vista ☐ Coronado ☐ Mesa Vista/McDonald Center ☐ Grossmont ☐ Memorial/Mary Birch/Outpatient Pavilion

☐ **Other**: Facility: Address:
City/State/Zip: Phone:

Release Records To:

Name of Person/Facility: _____ Phone: _____
Address/City/State/Zip: _____

Type of Information to be Released (*check all that apply*):

☐ Hospital Stay (history & physical, operative/lab/radiology reports, discharge summary, progress notes)
☐ Clinic/Outpatient Visit (office/procedure/operative notes, immunization, lab, diagnostic & radiology reports)
☐ Emergency Dept (dictation/notes, lab/radiology reports) ☐ Open Medical Record (during hospitalization)
☐ Other Records (Please specify): _____

Treatment Dates of Service Requested: _____

Delivery Method (*choose one*):

☐ Encrypted/Secure or ☐ Unencrypted Email: _____
☐ U.S. Mail ☐ Other: _____

Special authorization required: Records released may include information related to mental health, alcohol/drug, and HIV references. The actual mental health, substance use disorder treatment records and/or results of HIV tests will not be disclosed unless specifically requested below.
☐ HIV Test Results ☐ Mental Health Treatment Records ☐ Substance Use Disorder Treatment Records

Use of Information: The recipient identified above is permitted to use my PHI for (check one):
☐ Personal ☐ Legal ☐ Continued Medical Care – Appointment Date (if known): ___ ___ ___

Expiration: This authorization will expire one year from the date of signature below unless an earlier expiration date is indicated here: ___ ___ ___
_____ Initial here if this request requires future treatment notes to be disclosed to the same recipient named above. This will allow Sharp to release future treatment dates until expiration date.

By signing below, I acknowledge I have read and understand pages 1 and 2 of this authorization.
Printed Name: _____ Signature: _____ Date: _____
Indicate relationship if not the patient: ☐ Parent/Legal Guardian ☐ DPOA ☐ Other _____
Witness (optional): _____

SHC-MR-3794-NS

Patient Name: _____
Date of Birth: _____
Medical Record Number: _____
Label