Print Form

SHARP Rees-Stealy Medical Group

Health Information Management Department
2001 Fourth Ave, San Diego, CA 92101
Phone: (858) 637-6446 Fax: (858) 637-6469

Patient: _____

DOB: _____

MRN: _____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

All sections on page two of this authorization must be completely filled out before Sharp Rees-Stealy (SRS) is permitted to disclose or receive your protected health information (PHI).

EXPLANATION: This form authorizes the use or disclosure of protected health information in the manner described below and is voluntary. Refusal to sign will not affect your ability to obtain treatment from SRS. Please be aware that once your information leaves SRS, SRS 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 PROTECTED HEALTH INFORMATION: 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 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.

RESTRICTIONS: I understand that Sharp Rees-Stealy may not further use or disclose the information described on page two 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 Rees-Stealy from any/all liability that may arise from the release of this information to the party named on this form.

ADDITIONAL COPY: I further understand that I have a right to receive a copy of this authorization upon my 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: If your health information is being released directly to you, 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.

NON-SRS RECORDS: SRS may not retain all records received from outside providers. Please contact your non-SRS provider for complete copies of non-SRS records.

1. Authorization: I authorize disclosure of protected health information (PHI) as described below.

   Name of Patient: _____

   Telephone: (_____)_____ Date of Birth: _____/_____/ _____

2. Record Holder's Name: _____ Telephone: _____

   Address: _____

3. Release To: _____ Telephone: _____

   Address: _____

4. Type of Information (please *initial* each category of information to be released):

   ___Office Notes
   ___Operative/Procedure Reports
   ___Laboratory
   ___HIV (Human Immunodeficiency Virus) Test Results
   ___Mental Health Information
   ___Alcohol and/or Drug Abuse Information
   ___Non-Sharp Rees-Stealy Records
   ___Eye Notes
   ___PT/OT/Speech Therapy Notes
   ___Radiology Reports
   ___Radiology Films/Images
   ___Occupational Medicine
   ___Billing Information

   Other (Please specify): _____

5. Records Pertaining To: _____
   (Injury / Illness / Condition)

6. Dates of Service: From _____ To _____

   □ I <u>authorize</u> disclosure of my protected health information <u>after the date of my signature</u>, until the designated expiration as noted below, or revocation, whichever occurs first.
   □ I <u>do not authorize</u> disclosure of my protected health information <u>after the date of my signature</u>.

7. Use of Information: The individual or entity identified above is permitted to use my PHI for the following purposes. Please *initial* all that apply.

   ___Continuing Medical Care ___Personal ___Legal ___Insurance

   Other (Please specify): _____

8. I would like to receive my records: □ On Paper □ Electronically

   Email (required to receive records electronically): _____

9. Expiration Date: _____ If no date indicated, authorization will expire one year from date of signature.

10. Name (Print): _____ Signature: _____

    Date: _____ Witness (Optional): _____

    If you are not the patient, indicate relationship to patient: _____