



AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

Medical Record Number: _____

Label

Please read carefully and complete the reverse side of this form.

All sections of this authorization must be completely filled out before Sharp is permitted to disclose your protected health information.

EXPLANATION: This form authorizes the use or disclosure of protected health information in the manner described below and is voluntary. Sharp HealthCare will still provide medical treatment for you if you do not sign this authorization, except under limited circumstances that are described in our Notice of Privacy Practices. **Please be aware that once your information leaves Sharp HealthCare, Sharp HealthCare will no longer be able to protect that information, and the recipients of your information may not be legally required to protect your information.**

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 requested 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 apply to you, please notify your provider before beginning any procedure and consider notifying your employer.

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 try to exclude these types of information unless you specifically identify them for release.

RESTRICTIONS: I understand that Sharp HealthCare may not further use or disclose the information described on the reverse side 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 the reverse side of this form.

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

DURATION: I understand that I may revoke this authorization in writing at any time (see the Sharp HealthCare Notice of Privacy Practices for instructions), except to the extent that action has already been taken. Unless otherwise noted, this authorization will expire **one year** from the date of my signature.

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.

1. **Authorization:** I authorize disclosure of medical information and health records as described below:

Name of Patient: _____

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

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

Address: _____ City: _____ State: _____ Zip: _____

3. **Records Released To:** _____

Address: _____ City: _____ State: _____ Zip: _____

4. **Information to be Released for these Dates of Service:** From _____ To _____

5. **Information to Release:** Place your initials next to each category of information we will be releasing.

- | | |
|--|--|
| <input type="checkbox"/> HIV Test Results (Human Immunodeficiency Virus) | <input type="checkbox"/> Psychiatric Records |
| <input type="checkbox"/> Treatment for Alcohol and/or Drug Abuse | <input type="checkbox"/> Billing Information |
| <input type="checkbox"/> Operative/Procedure Reports | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Radiology/Nuclear Medicine Reports | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Emergency Department Reports | <input type="checkbox"/> Laboratory Tests |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> History/Physical Exam |
| <input type="checkbox"/> Still or Video Images and Sound Prepared for (Sharp/Non-Sharp) Marketing Purposes | |
| <input type="checkbox"/> Other (Please Specify): _____ | |

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

- | | | |
|--|---|------------------------------------|
| <input type="checkbox"/> Continuing Medical Care | <input type="checkbox"/> Second Opinion | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Print Marketing or Educational Media | <input type="checkbox"/> Personal | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Audio/Visual Marketing or Education Media | | |
| <input type="checkbox"/> Other (please specify): _____ | | |

7. **Signature:**

Printed Name: _____

Signature: _____ Date/Time: _____

If signed by other than patient, indicate relationship to patient: _____

Witness Signature: _____ Date/Time: _____
(Sharp HealthCare Representative)

Attending Physician (Required for Behavioral Health): _____

Date/Time: _____

8. **Mailing Instructions:** Please mail **both sides** of this authorization form to:

(Sharp staff to enter appropriate address)