SHARP®

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.

Please complete the reverse side of this form

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

   Name of Patient: _____

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

   Record Holder's Name: _____

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

   Records Released To: _____

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

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

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

   ___HIV Test Results (Human Immunodeficiency Virus)
   ___Treatment for Alcohol and/or Drug Abuse
   ___Operative/Procedure Reports
   ___Radiology/Nuclear Medicine Reports
   ___Emergency Department Reports
   ___Consultation Reports
   ___Infection Control/Clinical Information
   ___Psychiatric Records
   ___Billing Information
   ___Discharge Summary
   ___Progress Notes
   ___Laboratory Tests
   ___History/Physical Exam
   ___Still or Video Images and Sound Prepared for (Sharp/Non-Sharp) Marketing Purposes
   ___Other (Please Specify): _____
   ___I would like an electronic copy (e.g., compact disk) of the above indicated information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary and procedures, if available.)

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

   ____Continuing Medical Care ____Second Opinion ____Legal
   ____Print Marketing or Educational Media ____Personal ____Insurance
   ____Audio/Visual Marketing or Education Media
   ____Other (please specify): _____

5. **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: _____

6. **Mailing Instructions:** Please mail <u>both</u> <u>sides</u> of this authorization form to:

   _____
   (Sharp staff to enter appropriate address)