



Health Information Management Department
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(Mailing address only. No patient access.)
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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 is permitted to disclose or receive your protected health information.

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 Sharp Rees-Stealy. Please be aware that once your information leaves Sharp Rees-Stealy, 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 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.

RECEIVING RECORDS ELECTRONICALLY: This option is available for patient or patient representative requests; not businesses, medical providers or third parties. If you prefer this option provide an email address in number 4 in addition to your mailing address in number 3.

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: 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: Sharp Rees-Stealy may not retain all records received from outside providers. Please contact your non-Sharp Rees-Stealy provider for complete copies of those records.

Office use	<input type="checkbox"/> ID checked
Recd by/Site:	
Date/Time:	
SHC:	
MRN:	

- Name of patient:** _____
Telephone: (_____) _____ Date of birth: _____
- I hereby authorize:** _____
Address: _____ Telephone: (_____) _____
- To disclose to:** _____ Telephone: (_____) _____
Address: _____
- Email address to receive records electronically:** _____
- Use of information:** The recipient identified above is permitted to use my Protected Health Information for the following purpose (choose one):
 Continuing Medical Care Personal Second Opinion
 Provider Change (Insurance Change) Insurance (Life, Claims, etc.) Legal
 Provider Change (Please Specify): _____
- Dates of service:** From _____ To _____
- Only records pertaining to (optional):** _____
(Injury / Illness / Condition)
- Type of information to be released (Check all that apply):**
 Office Notes PT/OT/Speech Therapy Notes
 Operative/Procedure Reports Eye Notes
 Immunization Records Occupational Medicine
 Laboratory (Excludes HIV test results) Radiology Images with Reports
 Radiology Reports Only Other: _____

Release of the records within this box requires specific authorization. Please ***initial*** next to each type of information to be released.

HIV (Human Immunodeficiency Virus) Test Results Mental Health Information
 Alcohol and/or Drug Abuse Information

- Expiration date:** This authorization will expire one year from the date of signature below unless you indicate otherwise here _____.
 - For future use:** If you would like to allow Sharp Rees-Stealy to release notes for treatment dates past your signature date below, up until the authorization expiration date, please initial here _____.
 - By signing below I acknowledge I have read and understand pages one and two of this authorization and I allow Sharp Rees-Stealy to release my records to the requestor named above. I also acknowledge that I am responsible for all fees that ***may*** occur due to my records request. Initial here to be called for "fee approval" when costs exceed \$25.00 _____.
- Print Name:** _____ **Signature:** _____
Date: _____ **Witness (optional):** _____
- If you are not the patient, indicate relationship to patient: _____

Office use	Completed by:	Date:	DOS released:	Total pages:
Doc Types Released/ Comments:				