SHARP Rees-Stealy Medical Group
Health Information Management Department
5651 Copley Dr., Suite A, San Diego, CA 92111
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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 (SRS) is permitted to disclose or receive your protected health information (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 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 (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: 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 and select whether you would like to receive the records encrypted or unencrypted. Please do this 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: The requestor 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. Unless stated otherwise only amounts above $25 or higher will require fee-approval before copying.

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	□ ID checked
Recd by/Site:	
Date/Time:	
SHC:	
MRN:	

1. Name of patient: _____

   Telephone: (_____) _____ Date of birth: _____

2. I authorize: _____

   Address: _____ Telephone: (___) _____

3. To disclose to: _____ Telephone: (___) _____

   Address: _____

4. Email address to receive records electronically: _____

   Choose security option for email delivery:

   ___ Encrypted (Recipient will be required to create an account with Cisco envelope to access.)

   ___ Unencrypted (I understand that there is some risk that my identifiable health information and other confidential information may be misdirected, read or intercepted by unauthorized parties.)

5. Use of information: The recipient identified above is permitted to use my PHI for the following purpose (choose one):

   ___ Continuing Medical Care ___ Personal ___ Second Opinion

   ___ Provider/Insurance Change ___ Insurance (Life, Claims, etc.) ___ Legal

6. Dates of service: From _____ To _____

7. Only records pertaining to (optional): _____

8. Type of information to be released (Check all that apply):

   ___Office Notes
   ___Operative/Procedure Reports
   ___Immunization Records
   ___Laboratory (Excludes HIV test results)
   ___Radiology Reports Only
   ___Other: _____
   ___PT/OT/Speech Therapy Notes
   ___Eye Notes
   ___Occupational Medicine
   ___Radiology Images with Reports
   ___Billing

Records released as part of this authorization may include mention of HIV, mental health and alcohol or drug use. Mental health and/or alcohol/drug treatment facilities and/or results of HIV tests will not be disclosed unless you ***initial*** next to the specific information below.

___ HIV Test Results ___ Mental Health Treatment Records ___ Alcohol/Drug Treatment Records

9. Expiration: This authorization will expire one year from the date of signature below unless you indicate an earlier expiration date here _____. If the purpose of this request may require future treatment notes to be disclosed to the same recipient named above, you may initial here allowing SRS to release future treatment dates ____.

10. By signing below, I acknowledge I have read and understand pages one and two of this authorization.

    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: