SHARP Rees-Stealy Medical Group

For Office Use Only:
SHC: _____
MRN: _____
Received By/Site: _____
Date/Time: _____

Health Information Management Department
858-499-6446

Authorization to Release Medical Records to Sharp Rees-Stealy

Please fill out both pages of this form so that your provider will be able to review your medical history. Your protected health information will not be released to Sharp Rees-Stealy without a completed form. If you do not wish to release this information, it will not affect your ability to obtain treatment.

1. Patient name: _____

   Phone: _____ Date of birth: _____

2. I authorize (name of previous health care provider): _____

   Address: _____ Phone: _____

   To disclose to: Sharp Rees-Stealy Medical Centers
   4000 Ruffin Road, Suite R, San Diego, CA 92123
   858-499-6446 (phone) 858-636-2424 (fax)
   SRS.ROIRequest@sharp.com

3. Requested records will include: medications, allergies, immunizations, clinical notes, procedures and lab and radiology reports from the past two years.

   If additional records pertaining to a specific injury or illness need to be released, please specify:

   _____

   _____

   Especially sensitive information will be excluded unless it is specifically identified for release. To include this information, please **initial** next to any or all of the items below.

   I release the following additional information to Sharp Rees-Stealy.

   _____ (initials) Human immunodeficiency virus (HIV) test results
   _____ (initials) Mental health information
   _____ (initials) Alcohol and/or drug abuse information

4. By signing below, I acknowledge I have read and understand pages one and two of this authorization and I allow my records to be released to Sharp Rees-Stealy Medical Group. This authorization will expire one year from the date of signature.

   I voluntarily authorize the use or disclosure of my protected health information as described above.

   I understand that Sharp Rees-Stealy may not further use or disclose the information described above unless another authorization is obtained or unless such use or disclosure is specifically required or permitted by law.

   I understand that my previous health care provider may not be legally required to protect my information once it leaves their possession.

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

   I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken.

Print name: _____ Signature: _____

Date: _____ Witness (optional): _____

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

Form Instructions

Please return your completed form to Sharp Rees-Stealy in one of the following ways:

- Fax it to 858-636-2424, Attn: ROI Specialist
- Mail it to Sharp Rees-Stealy Central Records Room, Attn: Medical Records, 4000 Ruffin Road, Suite R, San Diego, CA 92123
- Email* it to srs.forms@sharp.com
- Bring it with you at the time of your appointment

*Your privacy is important to us. Please use the email option only if you have a personal email account that only you can access.