SHARP®

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

FOR HOSPITAL RECORD REQUEST

Return To: Health Information Management
8080 Dagget St. Suite 110
San Diego, CA 92111
SHC.Records@sharp.com
Phone: 858-541-5400
Fax: 858-636-2287

FOR REES-STEALY RECORD REQUEST

Return To: Health Information Management
8080 Dagget St. Suite 110
San Diego, CA 92111
SRSROIRequest@sharp.com
Phone: 858-262-6422
Fax: 858-636-2424

All sections must be complete before Sharp HealthCare may disclose 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 HealthCare. Please be aware that once your information leaves Sharp HealthCare, 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: If you prefer this option, provide an email address where directed and select whether you would like to receive the records encrypted or unencrypted. If you choose unencrypted, you understand that there is some risk that identifiable health information and other confidential information may be misdirected, read or intercepted by unauthorized parties. Please do this in addition to providing your mailing address.

RESTRICTIONS: I understand that Sharp HealthCare may not further use or disclose the information described on page 2 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 this form.

ADDITIONAL COPY: I 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.

OUTSIDE RECORDS: I understand it is the practice of Sharp HealthCare hospitals to retain all records received from outside providers. I further understand it is not the practice for Sharp Rees-Stealy to retain all outside medical records. If Sharp Rees-Stealy physicians choose not to maintain copies of your medical records from physicians outside of Sharp Rees-Stealy, you will need to contact your non-Sharp HealthCare provider for complete copies of those records.

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

SHC-MR-3794-NS

Patient Name: _____

Date of Birth: _____

Medical Record Number: _____

Label

SHARP

OFFICE USE	
SHC#:	Facility:
Received by:	
Date:	❑ ID Checked

Patient Name: _____

Date of Birth: _____ **Phone:** _____

Record holder: Choose from a Sharp facility below: (Check all that apply)

❑ Sharp Chula Vista ❑ Sharp Coronado ❑ Sharp Grossmont ❑ Sharp Mary Birch
❑ Sharp Mesa Vista ❑ Sharp Rees-Stealy ❑ Sharp Memorial/Outpatient Pavilion
❑ Other: _____

Release my records to: _____

Street Address City State Zip Code

Please issue records by: ❑ Mail on CD ❑ Electronic (encrypted) ❑ Electronic (*unencrypted)
❑ Print and Mail ❑ Print and Pick Up

Email address to receive records electronically: _____

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

❑ Progress Notes ❑ Emergency Dept. ❑ Discharge Summary ❑ Op/Procedure Reports
❑ Consultations ❑ Care Clinic ❑ History and Physical ❑ Occupational Medicine
❑ Lab (Excludes HIV) ❑ Eye Notes ❑ Genetic Testing ❑ PT/OT/Speech Therapy
❑ Immunizations ❑ Cardiology Images ❑ Radiology Reports Only ❑ Billing
❑ Radiology Images and Reports ❑ Open Medical Record
❑ One year of Rees-Stealy Records (Includes pertinent records for patients care, includes radiology and lab)
❑ Other: _____
❑ Only records pertaining to: (optional) _____

Treatment dates requested: From _____ To _____

Special authorization required: Records released may include information related to mental health, alcohol/drug, and HIV references. The actual mental health, substance use disorder treatment records and/or results of HIV tests will not be disclosed unless specifically requested below.

❑ HIV Test Results ❑ Mental Health Treatment Records ❑ Substance Use Disorder Treatment Records

Use of information: The recipient identified above is permitted to use my PHI for: (Check one)

❑ Continuing Medical Care ❑ Personal ❑ Second Opinion
❑ Provider/Insurance Change ❑ Insurance (Life, Claims, etc.) ❑ Legal

Expiration: This authorization will expire one year from the date of signature below unless you indicate an earlier expiration date of _____. 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 Sharp to release future treatment dates through the expiration _____.

By signing below, I acknowledge I have read and understand pages 1 and 2 of this authorization.

Printed Name: _____ **Signature:** _____

Date: _____ **Witness: (optional)** _____

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

Attending Physician: (Required for Behavioral Health) _____ Date: _____ Time: _____

OFFICE USE	Completed by:	Date:	DOS Released:	Total Pages:
	Documents Released/Comments:			

SHC-MR-3794-NS

Patient Name: _____

Date of Birth: _____

Medical Record Number: _____

Label