



AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

All sections must be complete before Sharp HealthCare may disclose your 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 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.

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 request.

REVOCACTION: 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



OFFICE USE			
SHC#:	User ID/Facility:	Date:	<input type="checkbox"/> ID Checked
Completed by: Documents Released/Comments:	Date:	DOS Released:	Total Pages:

Patient Name:		Birthdate:		Phone:	
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Obtain Records From (check all that apply):	<input type="checkbox"/> Sharp Rees-Stealy Medical Center <input type="checkbox"/> Sharp Hospital: <input type="checkbox"/> Chula Vista <input type="checkbox"/> Coronado <input type="checkbox"/> Mesa Vista/McDonald Center <input type="checkbox"/> Grossmont <input type="checkbox"/> Memorial/Mary Birch/Outpatient Pavilion <input type="checkbox"/> Other: _____ <div style="display: flex; justify-content: space-between; width: 100%;"> Facility Address City/State/Zip Phone </div>				
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Release Records To:	Name of Person/Facility: <u>Records Deposition Service</u> Phone: <u>(248) 357-3330</u> Address/City/State/Zip: <u>P.O. Box 5054, Southfield, MI 48086-5054 F (248) 357-3337</u>
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Type of Information to be Released (check all that apply):
<input type="checkbox"/> Hospital Stay (history & physical, operative/lab/radiology reports, discharge summary, progress notes) <input type="checkbox"/> Clinic/Outpatient Visit (office/procedure/operative notes, immunization, lab, diagnostic & radiology reports) <input type="checkbox"/> Emergency Dept (dictation/notes, lab/radiology reports) <input type="checkbox"/> Open Medical Record (during hospitalization) <input type="checkbox"/> Other Records (Please specify): _____

Treatment Dates of Service Requested: _____
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Delivery Method (choose one):	<input type="checkbox"/> Print & Mail <input type="checkbox"/> Print & Pick Up Email: <input type="checkbox"/> Encrypted/Secure <input checked="" type="checkbox"/> Unencrypted <input checked="" type="checkbox"/> Email address: <u>requests@recdep.com</u> ✓
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<p>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.</p> <input type="checkbox"/> HIV Test Results <input type="checkbox"/> Mental Health Treatment Records <input type="checkbox"/> Substance Use Disorder Treatment Records

<p>Use of Information: The recipient identified above is permitted to use my PHI for (check one):</p> <input type="checkbox"/> Personal <input checked="" type="checkbox"/> Legal <input type="checkbox"/> Continued Medical Care – Appointment Date (if known): ____/____/____
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<p>Expiration: This authorization will expire one year from the date of signature below unless an earlier expiration date is indicated here: ____/____/____.</p> <p>_____ Initial here if this request requires future treatment notes to be disclosed to the same recipient named above. This will allow Sharp to release future treatment dates until expiration date.</p>

<p>By signing below, I acknowledge I have read and understand pages 1 and 2 of this authorization.</p> <p>Printed Name: _____ Signature: _____ Date: _____</p> <p>Indicate relationship if not the patient: <input type="checkbox"/> Parent/Legal Guardian <input type="checkbox"/> DPOA <input type="checkbox"/> Other _____</p> <p>Witness (optional): _____</p>
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 SHC-MR-3794-NS	Patient Name: _____ Date of Birth: _____ Medical Record Number: _____ <div style="text-align: right;">Label</div>
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