



Patient Name: _____
Date of Birth: _____
Medical Record Number: _____

(LABEL)

**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**Please read carefully and complete the reverse side of this form**

**All sections of this authorization must be completely filled out before Sharp is permitted to disclose your protected health information.**

**EXPLANATION:** This form authorizes the use or disclosure of protected health information in the manner described below and is voluntary. Sharp HealthCare will still provide medical treatment for you if you do not sign this authorization, except under limited circumstances that are described in our Notice of Privacy Practices. **Please be aware that once your information leaves Sharp HealthCare, Sharp HealthCare will no longer be able to protect that information and the recipients of your information may not be legally required to protect your information.**

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

**AUTHORIZATION TO DISCLOSE SPECIFIC PROTECTED HEALTH INFORMATION:** Federal and State laws require us to obtain specific authorization from patients to release 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 try to exclude these types of information unless you specifically identify them for release.

**RESTRICTIONS:** I understand that Sharp HealthCare may not further use or disclose the information described on the reverse side 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 legal liability that may arise from the release of this information to the party named on the reverse side of this form.

**ADDITIONAL COPY:** I further understand that I have a right to receive a copy of this authorization upon my request.

**DURATION:** I understand that I may revoke this authorization in writing at any time (see the Sharp HealthCare Notice of Privacy Practices for instructions), except to the extent that action has already been taken. Unless otherwise noted, this authorization will expire **one year** from the date of my signature.

1. **Authorization:** I authorize disclosure of medical information and health records as described below:

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_  
(Optional)

2. **Record Holder:** \_\_\_\_\_  
(Hospital, Medical Group or other Service Provider)

Street Address City State Zip

3. **Records May Be Released To:** \_\_\_\_\_

Street Address City State Zip

4. **Type of Information:** This authorization **does not** apply to the following types of information unless my initials appear beside each applicable category.

Psychiatric Records  Treatment for Alcohol and/or Drug Abuse Treatment  
 HIV Test Results (Human Immunodeficiency Virus)  
 Discharge Summary  Progress Notes  History/Physical Exam  
 Laboratory Tests  Consultation Reports  Radiology/Nuclear Medicine Reports  
 Operative/Procedure Reports  Billing Information  Emergency Department Reports  
 Still or Video Images and Sound Prepared for (Sharp/Non-Sharp) Marketing Purposes  
 Other (Please Specify) \_\_\_\_\_

5. **Dates of Service:** (From) \_\_\_ / \_\_\_ / \_\_\_ -- (To) \_\_\_ / \_\_\_ / \_\_\_

6. **Use of Information:** The individual or entity identified above is permitted to use my information for the following purposes: **Please initial all that apply.**

Continuing Medical Care  Second Opinion  Personal  Insurance  Legal  
 Audio/Visual Marketing or Education Media  Print Marketing or Educational Media  
 Other (please specify) \_\_\_\_\_

7. **Duration:** This authorization is valid for one year from the date next to my signature unless otherwise noted here: \_\_\_\_\_

8. **Signature:**  
Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

If signed by other than patient, indicate relationship to patient: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

(Sharp HealthCare Representative)

Attending Physician Signature (Required for Behavioral Health: \_\_\_\_\_ Date/Time: \_\_\_\_\_

9. **Mailing Instructions:** Please mail **both sides** of this authorization form to:

(Sharp staff to enter appropriate address)