SHARP Rees-Stealy Medical Group

PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION

In order to protect your privacy and provide the best possible customer service, Sharp Rees-Stealy (SRS) allows you to tell us who we may communicate with about your medical care/condition.

EXPLANATION: This optional form authorizes SRS to communicate with the named person in the manner described below. This does not give the authorized person the ability to request copies of your medical records. Refusal to sign will not affect your ability to obtain treatment from SRS. Please be aware that once your information leaves SRS, SRS 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: 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. Sensitive information will be excluded unless you specifically identify them for release.

RESTRICTIONS: I understand that SRS may not further use or disclose the information described in 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 SRS 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.

Please call 858-616-8055 if you have any questions.

Send completed forms to Sharp Rees-Stealy Medical Group, Health Information Management

Email: SRS.Forms@sharp.com
Fax: 858-636-2424
Mail: 2020 Genesee Avenue
San Diego, CA 92123

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Patient Name:______________________________ DOB:____________ EMRN: ________________________

I have reviewed page one of this form and authorize Sharp Rees-Stealy to discuss the following information about me:

___ Medical: ALL (i.e. diagnosis, test results, treatment, and medications)
___ Medical: ONLY concerning the following diagnosis: ____
___ Billing: ALL
___ Billing: ONLY concerning the following diagnosis: ____

Authorization to discuss the information contained in this box requires specific authorization. Please *initial* next to each type of information that can be discussed.
___ Human Immunodeficiency Virus (HIV) test results ___Mental Health Information
___ Alcohol and Chemical dependency information

I authorize disclosure of the above specified information to:

1. Name:____

   Telephone:_____________Date of Birth:_________Relationship to Patient: _______________________

2. Name:____

   Telephone:_____________Date of Birth:_________Relationship to Patient: _______________________

Expiration Date:_________________If no date is indicated, authorization will expire one year from date of signature. (MM/DD/YY)

Print Name: ____

Signature:____

Date:______________________________________ **Witness (Optional):** ________________________

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