SHARP Rees-Stealy Medical Group

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

All sections on page two of this authorization must be completely filled out before Sharp Rees-Stealy (SRS) is permitted to disclose or receive your protected health information (PHI).

EXPLANATION: This form authorizes the use or disclosure of protected health information in the manner described below and is voluntary. 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 especially 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 automatically exclude these types of information unless you specifically identify them for release.

RESTRICTIONS: I understand that Sharp Rees-Stealy may not further use or disclose the information described on page two 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 Rees-Stealy 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.

CHARGES: If your health information is being released directly to you, 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.

NON-SRS RECORDS: SRS may not retain all records received from outside providers. Please contact your non-SRS provider for complete copies of non-SRS records.

Office use	□ ID checked
Recvd by/Site:	
Date/Time:	
EMRN:	
OMRN:	

1. Name of patient: _____

   Telephone: (____) _____ Date of birth: _____/_____/_____

2. I hereby authorize: _____

   Address: _____ Telephone: (___) _____

3. To disclose to: _____ Telephone: (___) _____

   Address: _____

4. Use of information: The recipient identified above is permitted to use my PHI for the following purposes. Please *initial* all that apply.

   ___Continuing Medical Care ___Personal ___Legal ___Insurance

   Other (please specify): _____

5. Dates of service: From _____ To _____

6. Only records pertaining to (optional): _____

   (Injury / Illness / Condition)

7. Type of information to be released (please *initial* next to each applicable type to be released):

   ___Office Notes
   ___Operative/Procedure Reports
   ___Immunization Records
   ___Laboratory (Excludes HIV test results)
   ___Radiology Reports Only
   ___Eye Notes
   ___HIV (Human Immunodeficiency Virus) Test Results
   ___PT/OT/Speech Therapy Notes
   ___Mental Health Information
   ___Alcohol and/or Drug Abuse Information
   ___Non-Sharp Rees-Stealy Records
   ___Radiology Images with Reports
   ___Occupational Medicine
   ___Billing Information

   Other (Please specify): _____

8. I would like to receive my records: □ On Paper or □ Electronically

   Email (to receive records electronically): _____

9. Expiration date: This authorization will expire one year from the date of signature. You may otherwise indicate a different expiration date (note here): _____. If you would like to extend this authorization for <u>treatment dates</u> past your signature below please initial here _____.

10. By signing below I acknowledge I have read and understand pages one and two of this authorization and I allow Sharp Rees-Stealy to release my records to the requestor named above. I also acknowledge that I am responsible for all fees that <u>*may*</u> occur due to my records request. Initial here to be called for "fee approval" for costs exceeding $25.00. _____

    Name (print): _____ Signature: _____

    Date: _____ Witness (optional): _____

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

Office use	Completed by:	Date:	DOS released:	Total pages:
Comments:				
Doc types released:				