



## PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION

**In order to protect your privacy and provide the best possible customer service, Sharp HealthCare allows you to tell us who we may communicate with about your medical care/condition.**

**EXPLANATION:** This optional form authorizes Sharp HealthCare 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 Sharp HealthCare. 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.

**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 Sharp HealthCare 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 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 further understand that I have a right to receive a copy of this authorization upon my 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.

Please call 858-541-5400 if you have any questions.  
Send completed forms to Sharp HealthCare, Health Information Management

Email: [SHC.Records@sharp.com](mailto:SHC.Records@sharp.com)  
Fax: 858-636-2287  
Mail: 300 Fir St.  
San Diego, CA 92101

**PERMISSION TO DISCUSS  
PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SHC: \_\_\_\_\_

**I have reviewed page one of this form and authorize Sharp HealthCare 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: \_\_\_\_\_