SHARP Health Plan

Authorization for use or disclosure of health information

Purpose

Completing this form gives Sharp Health Plan permission to share your personal health information. You control who you want to share that information with and the level of information that you want to share with them.

Instructions

Complete this document to authorize the disclosure and/or use of your individually identifiable health information, as set forth below, consistent with California and federal law concerning the privacy of such information. Failure to provide all information may invalidate this authorization.

Submit

Please submit the finished form by mail, in person or fax:

By mail or in person:
Sharp Health Plan
8520 Tech Way, Ste. 200
San Diego, CA 92123-1450

By fax:
1-619-740-8571

Please visit **sharphealthplan.com/phiform** for more information.

Note: This authorization is for Sharp Health Plan only. You must complete additional authorization forms and submit them to your medical group, doctor's office or locations where you receive care. We encourage you to contact your doctor's office or your hospital to ask for the correct form.

1. Use and disclosure of protected health information		
I, ___________________________ (your name), authorize Sharp Health Plan to disclose my health information.		
Person/organization I authorize to receive my health information:		
Name:		
Address:		
City:	State:	ZIP code:
Relationship to member:	Phone number:	

This authorization applies to the following information (select one of the following options):

- ☐ **All health information** including medical and financial information (e.g., diagnoses, providers, treatments, drugs, medical claims, bills, copayments) OR
- ☐ **Only limited information**

  Specify type of information: ____________________

  Specify date range: ____________________

Federal and state laws require us to obtain specific authorization 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. We will automatically try to exclude these types of information unless you specifically identify them for release. Please check below if you authorize Sharp Health Plan to release any or all of the following sensitive information.

I also specifically authorize the release of the following types of sensitive information (check all that apply):

- ☐ Psychiatric care
- ☐ Substance abuse including diagnosis or treatment of a drug or alcohol-related problem
- ☐ HIV and AIDS test results
- ☐ Mental health treatment or counseling services
- ☐ Medical care related to the prevention or treatment of pregnancy
- ☐ Care related to an infectious, contagious or communicable disease
- ☐ Diagnosis or treatment of rape or sexual assault
- ☐ Diagnosis or treatment of an injury related to intimate partner violence

2. Designation of personal representative

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), you have a right to nominate one or more persons to act on your behalf with respect to your protected health information (PHI). Your personal representative is given all of the privileges that you have with respect to your PHI. Your personal representative may receive your PHI and also has the authority to modify your Sharp Health Plan account (e.g., update your address, change your primary care physician). A personal representative may be a spouse, relative, domestic partner or friend. You are not required to have a personal representative, but if you want to designate someone who can receive your PHI and modify your Sharp Health Plan account, please complete the information below.

The person named below (same as individual named in section 1) is to also be given all of the privileges that would be given to me regarding my protected health information.

Personal representative name (individual named in section 1):

3. Expiration

This authorization will expire on (insert date): ____________________.

If no expiration date is selected, this document will be in effect until my coverage with Sharp Health Plan ends or until I send a written request to revoke this authorization.

4. Notice of rights and other information

- I may refuse to sign this authorization.
- I may revoke this authorization at any time by signing the revocation section and sending this form to Sharp Health Plan. My revocation will be effective upon receipt but will not be effective to the extent that others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.
- I understand that Sharp Health Plan will not condition treatment, payment, enrollment or eligibility for benefits on my providing or refusing to provide this authorization, except under limited circumstances described in the Notice of Privacy Practices.
- I understand information disclosed pursuant to this authorization could be redisclosed by the recipient and might not be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- I may inspect or obtain a copy of the health information that I am authorizing for use or disclosure.
- I understand that Sharp Health Plan may not use or disclose my PHI other than for the purposes described on 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 Health Plan from any and/all liability that may arise from the release of this information to the party named on this form.

5. Signature

Name (printed):	Member ID:
Signature:	Date (MM/DD/YYYY):

If signed by someone other than the member (such as a guardian or conservator), please complete the following:

Name (printed):	Relationship to member:

6. Revocation

You may revoke this authorization at any time by signing and dating this section of the form and returning it to Sharp Health Plan. You should only sign this section if you want to cancel this authorization.

I hereby revoke this authorization and/or designation of personal representative immediately.

Signature:	Date (MM/DD/YYYY):