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.

**Use this form to:**

1. Share all health information with the person or organization you choose, or only share limited information
2. Designate a personal representative to act on your behalf

**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 plan 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 or organization I authorize to receive my health information (only one person or only one organization per form):** | | |
| 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 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 not disclose information related to sensitive services without permission granted through this form. 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 is to be given all of the privileges that would be given to me regarding my protected health information.**

Personal representative name:

## 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 notifying Sharp Health Plan in writing. My revocation will be effective upon receipt but will not be effective to the extent that others have acted in reliance upon this authorization. For ease of processing, Sharp Health Plan requests that you email your revocation to **customer.service@sharp.com**.
- 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 or state confidentiality law (eg HIPAA).
- 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 will not disclose my PHI pursuant to this form, other than as I have directed in this form, except as 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: |