Scripps | Scripps Health Plan

*Member MRN: _____

Plan Use Only

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

EXPLANATION: This form authorizes the use or disclosure of PHI in the manner described below and is voluntary. Scripps Health Plan (SHP) cannot condition services on whether or not you sign this authorization except under limited circumstances such as for services related to research, eligibility or enrollment determinations, or services performed solely to create information for an outside requestor (such as worker's compensation). In these circumstances, SHP may refuse services unless you provide an authorization for the disclosure of your information. Please be aware that once your information leaves SHP, SHP will no longer be able to protect that information, and the recipients of your information may not be legally required to protect your information.

Member Information		
Member's Name and address (please print)		
Member ID Number	Telephone Number	Date of Birth (MM/DD/YYYY)

I would like the Health Information:		
☐ **Mailed**	☐**Emailed:** ☐ Secured ☐ **Unsecured	☐**Faxed**

**If sent by un-Secured email the information will not be encrypted, and could therefore be intercepted and viewed. SHP is not responsible for unauthorized access of your health information while in transmission to the email address you designated above.

Health Information to be Released: *What do you want sent or released?*

☐ Any or all information Scripps Health Plan maintains (this may include information relating to the Member's medical care, diagnosis, providers, insurance or benefit claims/payments, and/or financial/billing information. This does not include Sensitive information unless specifically approved below.

☐ Only the following information, or types of information, Scripps Health Plan maintains (specify):

_____

Release Records to: *Where do you want records sent? Who do you want to receive records*

Recipients name and address			Phone Number
Street Address	City	State	Zip
Fax	Email		

Purpose/Use of the Information

☐Continued Care ☐Legal ☐Personal ☐Other: _____

☐**NO** ☐**Yes** Complete this section **ONLY IF** you wish to authorize disclosure of any of the following types of Sensitive Information (check all that apply):

□ Abortion	□ Alcohol/Substance abuse	□ Genetic Information
□ HIV/AIDS	□ Mental Health	□ Pregnancy
□ Sexual, physical, or mental abuse		□ Sexually transmitted illness

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, Alcohol or Drug Abuse Treatment. Be aware that we will try to exclude these types of information unless you specifically identify them for release.

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NOTE TO PARENTS/LEGAL GUARDIANS OF MINORS 12 YEARS OF AGE OR OLDER:	
You may be unable to obtain or authorize the use of disclosure of certain types of Sensitive Information about the minor without the minor's own written authorization. This may include the types of Sensitive Information listed above as well as information regarding infectious diseases, rape/sexual assault, and certain outpatient mental health counseling/treatment. If the minor is 17 years of age or older, disclosure of information relating to domestic violence and blood donations also requires the minor's authorization.	
Duration/Expiration/Revocation	
I understand this authorization may be revoked in writing at any time, according to the instructions in the Scripps Health Plan's Notice of Privacy Practices, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization is valid for one year.	Date (MM/DD/YYYY)
Name/Signature of Patient or Authorized Representative	
Signature	Date (MM/DD/YYYY)
Print Name	
TYPES OF ACCEPTABLE AUTHORIZATIONS: Legal authorization is required for someone other than the patient to sign this form. These can include: Designated Power of Attorney (DPOA); Designated Personal Representative (DPR); Conservatorship; Parent/ Legal Guardian.	
If signed by other than member, indicate authorization ☐DPOA ☐DPR ☐Parent/Legal Guardian ☐ Other: _____ Relationship to Member:_____	
RESTRICTIONS: I understand that SHP may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by laws. I hereby release SHP from any/all legal liability that may arise from the release of this information to the party named on Page 1 of the Authorization Form.	

Please keep a copy of this Authorization for your records, sign and return this completed form to:

Scripps Health Plan
Mail Drop: 4S-300
10790 Rancho Bernardo Rd.
San Diego, CA 92127

Or you can fax it to: **858-964-3102**

Or you can email to: CustomerService@ScrippsHealth.org