



**AUTHORIZATION FOR RELEASE OF
PROTECTED HEALTH INFORMATION (PHI)**

As required by the Health Information Portability and Accountability Act of 1996, I have a right to nominate one or more persons to act on my behalf with respect to the protection of health information that pertains to me. My health record is private and is known under the law as "Protected Health Information (PHI)."

By completing and signing this form, I, or my legal representative, agree to allow Scripps Health Plan to share my PHI with the individual(s) or company(ies) listed below. By Scripps Health Plan, I also mean the company's subsidiaries, affiliates, employees, agents and subcontractors.

1. Person whose information is to be disclosed (the "Member")

Member's Name and address: (please print)		
Member ID Number	Member's Telephone Number	Date of Birth / /

2. Who is authorized to receive the Member's Information (the "Recipient")

Recipients name and address	Phone Number
Recipients relationship to the Member	

3. What information may be disclosed to the Recipient? (Check one):

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)

4. Is the Recipient authorized to receive Sensitive information?

NO – PROCEED TO SECTION 5

YES – Complete EITHER (a) or (b) below – you may not select both, I specifically authorize the Recipient to receive:

a) Psychotherapy notes – **If you check this box, you may not check any of the other boxes in section b, below.** An Authorization for the release of psychotherapy notes may not be combined with an Authorization for disclosure of any other type of information, **PROCEED TO SECTION 5**

b) Complete this section **ONLY IF** you did not check box 4(a) above, and you wish to authorize disclosure of any of the following types of Sensitive Information (check all that apply):

<input type="checkbox"/> Abortion	<input type="checkbox"/> Alcohol/Substance abuse	<input type="checkbox"/> Genetic Information
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Sexual, physical, or mental abuse	<input type="checkbox"/> Sexually transmitted illness	

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.



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5. What is the purpose of the request:

<input type="checkbox"/> The information is about me and is to be used or disclosed at my request <ul style="list-style-type: none"> <input type="radio"/> To resolve a claim dispute or appeal <input type="radio"/> Other (please specify):

6. Expiration and revocation

This Authorization will remain in effect for one year from the date you sign it (below) unless a different date is specified here:	Date (MM/DD/YYYY) ____/____/____
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You have the right to revoke this Authorization at any time by notifying Scripps Health Plan in writing. Revoking this Authorization will not affect information we use or disclose before we receive your revocation request. If this Authorization is given by a parent or legal guardian on behalf of a minor, it will expire on the minor's eighteenth (18) birthday.

7. Signature

I have read this form and I understand and agree to its terms. I direct Scripps Health Plan to use or to disclose the information to the noted recipient as directed above. I understand that once my information is disclosed, it could be re-disclosed by the Recipient and may no longer be protected by privacy laws, including the federal Health Insurance Portability and Accountability Act of 1996.

I understand that Scripps Health Plan may not condition payment, enrollment in a health plan, or eligibility for benefits on whether I sign this Authorization.

Signature	Date (MM/DD/YYYY)
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Print Name

If this form is signed by someone other than the Member or the parent of a minor, such as a personal/legal representative, guardian, or executor, **you must also submit legal documentation** showing your authority to act on behalf of the Member (or the Member's estate) to authorize the use or disclosure of the Member's health Information. Such documentation may include, for example: 1) Durable Health Care Power of Attorney; 2) current, valid documentation of court-ordered guardianship; or 3) other valid legal documentation showing your authority to act on behalf of the Member (or the Member's estate).

Please also complete the following

Representative's name: (please print)

Relationship to Member:

Type of document submitted:

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

Scripps Health Plan Services
Mail Drop: 4S-300
10790 Rancho Bernardo Rd
San Diego, CA 92127
Or you can fax it to: 858-964-3102