*MRN: ____________________________
Facility Use Only

SCRIPPS
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION VIA EMAIL

In order for Scripps to email a copy of your health information to you, or your designee, please complete the following information.

Email address you would like the information sent to:

____

I would like my information sent in a ☐ secure or ☐ unsecure manner (check one)

I acknowledge that by electing to receive my health information via email in an unsecure manner, that the information will not be encrypted, and that it could be intercepted and viewed by a third party. Scripps is not responsible for unauthorized access of your health information while in transmission to the email address you designate above.

Printed Name: ____

Signature:________________________________ Date: ______________________

If signed by other than patient, indicate relationship: _________________________

Witness:____

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