Scripps

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Please read carefully and complete page 2 of this form.
All sections of this authorization must be completely filled out before Scripps is permitted to disclose your protected health information.

EXPLANATION: This form authorizes the use or disclosure of protected health information in the manner described below and is voluntary. Scripps 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, Scripps may refuse services unless you provide an authorization for the disclosure of your information. **Please be aware that once your information leaves Scripps, Scripps will no longer be able to protect that information, and the recipients of your information may not be legally required to protect your information.**

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. If you know your record contains this type of information, you must identify the specific type of information found under the section labeled **Special Categories of Information**. If you choose not to release this information, please notify us immediately.

DURATION: I understand this authorization may be revoked in writing at any time, according to the instructions in the Scripps 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.

RESTRICTIONS: I understand that Scripps 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 Scripps from any/all legal liability that may arise from the release of this information to the party named above.

ADDITIONAL COPY: I further understand that I have a right to receive a copy of this authorization upon my request.

Please initial that you have read the above statements _____

Printed Name **Initials**

Complete page 2 of this form.

Scripps

MRN: _____
Facility Use Only

Authorization: I authorize the release of information pertaining to medical history, mental or physical condition, services rendered, or treatment, as described below for;

Name of Patient: _____ Date Of Birth: ____/____/____

Social Security Number: _____-_____-_____ Telephone: ( ) _____

Record Holder: _____

_____
Street Address City State Zip

Records May Be Released To: _____

_____
Street Address City State Zip

( ) _____ ( ) _____
Phone Fax

Date of Service: From____/____/____ To ____/____/____

Location of Treatment: ☐ Inpatient ☐ Emergency ☐ Outpatient

Type Of Information: This authorization is limited to the following medical records and type of information:

☐ Discharge Summary
☐ History/Physical Exam
☐ Consultation Reports
☐ Operative/Procedure Reports
☐ Emergency Department Reports
☐ Progress Notes
☐ Laboratory Tests
☐ X-ray reports
☐ Photographs, videotapes, digital or other images
☐ Other (please specify):_____

Special Categories of Information: You must specifically authorize the disclosure of the following types of information: Check all that apply:
☐ **HIV (Human Immunodeficiency Virus) test results** ☐ **Psychiatric records**
☐ **Alcohol and/or drug abuse treatment**

Use of Information: The requestor may use the medical records and type of information authorized only for the following purposes:
☐ Continuing Care ☐ Second Opinion ☐ Personal ☐ Insurance Claim
☐ Other (Please specify): _____

Printed Name:_____

Signature:_____ Date: _____

If signed by other than patient, indicate relationship: _____

Witness: _____

I hereby authorize release of all information as stated above:

Attending Physician (if appropriate):_____ Date: _____