*MRN: ________________________________
Facility Use Only

Request /Authorization for Health Information (Medical Records)

Patient Information	
*Patient Name:	Also known as:
*Date Of Birth: / /	*Telephone: ( ) -

***Record Holder:** *Who has the information you want released?*

☐ Scripps Health ☐ Healthcare facility if not Scripps (include Facility Name, MD office address):

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

☐ OTHER (Complete section below)

Name			Phone:
Street Address	City	State	Zip
FAX:	Email:		

***I would like the Health Information:**

Sent as a ☐ CD ☐ Paper ☐ Faxed ☐ E-Mailed | ☐ Secured ☐ Unsecured

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

Routine Record Sets **- For Dates of Service: FROM:** **TO:**

☐ Hospital Stay (History and physical, operative report, discharge summary, progress notes, lab, radiology reports)

☐ Clinic Visit (office notes, procedure notes, operative notes, lab, diagnostic and radiology reports)

☐ ED Visit (Dictation/notes, lab and radiology reports) ☐ Other Records (*Please Specify*): ________________

☐ Radiology Images Sent as: ☐ CD ☐ Nucleus.io Imaging Cloud (**valid email must be provided above)

Sensitive Information - I Specifically authorize release of:

☐ Mental Health Records	☐ Drug & Alcohol Treatment Records	☐ HIV Test Results

***Purpose/ Use of the Information:**

☐ Continued Care ☐ Legal ☐ Personal ☐ Other:

Name/Signature of Patient or Authorized Representative

*Printed Name:	*Date/Time:
*Signature:	

If signed by other than patient, indicate authorization: ☐ DPOA ☐ DPR ☐ Parent/ Legal Guardian
☐ Other:

Witness (Required if Signed by other than patient) :

All * items need to be completed prior to fulfilling request

Facility Use Only
Records given to Requestor ☐ Initials & Corp ID ________________
Scanned to Patient Chart ☐ Initials & Corp ID ________________

ROI 100-8700-739SW

WHITE - Medical Record Copy YELLOW - Requestor Copy

100-8700-739SW (Rev. 10/15/21)

REQUEST / AUTHORIZATION FOR HEALTH INFORMATION (MEDICAL RECORDS)

**Please read carefully and complete the reverse side of this form.
All sections of this authorization must be completely filled out before Scripps is permitted to provide or 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.

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

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 on Page 1 of the Authorization Form.

CHARGES: There is no charge for records to be sent to another health care provider. Records released directly to the patient or an authorized representative may be subject to charges; there will be a one-time fee of **$5** for each patient request. Additional charges may apply for any records produced in an electronic format over 250 pages at **$0.02**/page and/or a paper format over 50 pages at **$0.10**/page. The fee covers clerical costs as well as any/all costs associated with copying of the information. **Radiology Images Fees:** Unless being sent directly to a provider, **$6.50** for a CD copy or Nucleus.io Imaging Cloud upload.

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

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