Authorization of Release

Use & Disclosure of Protected Health Information

HIPAA, federal regulations and California law require that this Authorization be completed to authorize Inland Empire Health Plan (IEHP) to use and disclose Protected Health Information (PHI).

I ______________________ authorize IEHP to use or disclose this Member's PHI, as described below:

MEMBER INFORMATION

REQUIRED

Member Name | Member ID # or Social Security # | Date of Birth

Street address (for delivery) | Apt/Unit #

City | State | Zip Code | **Phone #**

RECORD REQUEST

REQUIRED

Please indicate the type of PHI records you are requesting:*

- ☐ Prescription
- ☐ Grievance & Appeals Case Management
- ☐ Referrals/Authorizations
- ☐ Claims/Billing
- ☐ Enrollment/Eligibility

Enter the date range of PHI records needed: ___/___/_____ to ___/___/_____

Please indicate the purpose(s) for disclosing or using PHI:

☐ Legal ☐ Personal Use ☐ Insurance ☐ Other (Please specify) ______________________

* IEHP does not maintain individual medical and/or clinical records. These records are in the custody of the professionals/entities that provided the healthcare service(s) i.e., Primary Care Physicians, Specialists, Hospitals, etc.

AUTHORIZATION

REQUIRED

I read this Authorization and agree to the use and disclosure of PHI as specified.

Name of Member (printed) | Signature of Member | Date

If signing for the Member, then describe your authority to act on the Member's behalf *(e.g., parent of minor child or legal guardian):* ______________________

Note: Appropriate documentation of the legal representative's authority must be on file with IEHP.

Name of Member's Legal Representative (printed) | Signature of Member's Legal Representative | Date

The Authorization is effective immediately and will remain in effect until ___/___/_____.
(ending date)

FOR INTERNAL USE ONLY
Authorization contains Privileged and Confidential Information.

Rev. 6/2020

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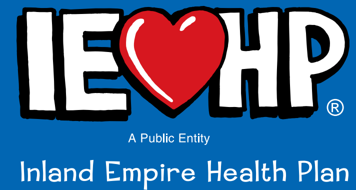

Inland Empire Health Plan

SPECIFIC AUTHORIZATIONS

OPTIONAL

Specific Authorizations:

PHI records of substance abuse, mental health conditions, and HIV information will not be disclosed without specific authorization. If you request the use and disclosure of such records, please give specific authorization by initialing in the appropriate box(es) below:

- ☐ Drug/Alcohol Abuse Treatment Information
- ☐ Mental Health Treatment Information *(does NOT include psychotherapy notes)*
- ☐ HIV Test Results and Treatment Information
- ☐ Other ______________________________

RECORD DELIVERY

REQUIRED

Delivery Options: (please check one)

☐ Pick-up at IEHP (Temporary hours for pickup are Fridays 8am to 12pm)*

* If you choose to pick up your records, the IEHP Legal Department will contact you when your records are available. Your records will be available for pick up for 14 business days. If your records are not picked up within 14 business days, they will be destroyed.

☐ FedEx Delivery (No fee to member): No P.O Box Available

Delivery Address ______________________________

☐ Secure E-mail Portal*

E-mail Address ______________________________

* In order to protect your privacy, IEHP delivers PHI using a secure e-mail portal. Upon request, IEHP can deliver your PHI using an unencrypted and unsecure e-mail portal. However, IEHP is not responsible or liable for breaches that may occur if PHI is sent using an unencrypted and unsecure e-mail. If you are requesting IEHP deliver your PHI using an unencrypted and unsecure e-mail portal, and accept the security risks with using this method, please initial here ______.

If delivering to a person/entity other than yourself or your legal representative, please state the name and contact information of the person/entity authorized to receive your PHI records:

____

Name | Relationship to Member

____

Contact Information for Delivery *(if different from above)*

DISCLOSURES

NOTICE OF RIGHTS AND OTHER INFORMATION

I understand that I do not have to sign this Authorization. My refusal will not affect my ability to obtain treatment, payment or eligibility for benefits. I am aware that I have a right to revoke this Authorization at any time, provided that my revocations in writing. I understand that I have a right to receive a copy. I further understand that if the information provided by this Authorization is disclosed (given) to another person or agency, it may no longer be protected by federal confidentiality law (HIPAA). However, California law does not allow the person receiving the health information by this Authorization to disclose it, unless a new Authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

IEHP will act on this request within 30 days of the date the Authorization was received, or within 60 days if the requested information is not maintained or accessible to IEHP on-site.

Please complete all required sections, sign and return this Authorization to:

Inland Empire Health Plan | Attn: Legal Department
P.O. Box 1800 | Rancho Cucamonga, CA 91729
Fax: 909-477-8578 | Email: Legal@iehp.org

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