

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

Please indicate the type of PHI records you are requesting:*			REQUIRED
<input type="checkbox"/> Prescription	<input type="checkbox"/> Grievance & Appeals Case Management	<input type="checkbox"/> Referrals/Authorizations	
<input type="checkbox"/> Claims/Billing	<input type="checkbox"/> Enrollment/Eligibility		
Enter the date range of PHI records needed: ____ / ____ / ____ to ____ / ____ / ____			
Please indicate the purpose(s) for disclosing or using PHI:			
<input type="checkbox"/> Legal	<input type="checkbox"/> Personal Use	<input type="checkbox"/> Insurance	<input type="checkbox"/> 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

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

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SPECIFIC AUTHORIZATIONS

Specific Authorizations:

OPTIONAL

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

Delivery Options: (please check one)

REQUIRED

- Pick-up at IEHP (Monday – Friday, 8am - 11am and 1pm - 3pm)*
* 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
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

FOR INTERNAL USE ONLY

Authorization contains Privileged and Confidential Information.

Rev. 11/2017