Authorization of Release

Use & Disclosure of Protected Health Information

IEHP
A Public Entity
Inland Empire Health Plan

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).

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

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) _____
☐ Care Management ☐ Care Coordination

* 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.

SPECIFIC AUTHORIZATIONS

REQUIRED

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
☐ HIV Test Results and Treatment Information
☐ I do not request the disclosure of such records
☐ Mental Health Treatment Information *(does NOT include psychotherapy notes)*
☐ Other _____

RECORD DELIVERY

REQUIRED

Delivery Options: (please check one)

☐ Pick-up at IEHP (Temporary hours for pickup are Fridays 8am to 11am)*

* 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 _____.

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AUTHORIZATION

REQUIRED

I hereby authorize: _____

(Please list IEHP here if you are requesting records from IEHP. If not, please list the name or description of the person or entity to which you are requesting the disclosure of records from)

Address: _____

City, State, Zip Code: _____

Phone: _____

To release information to: _____

(Please list your name here if use and/or disclosure will be made to you. If not, please list specify the name of the person or entity to which the use and/or disclosure will be made to, such as a family member, attorney, facility, provider, IEHP, etc.)

Address: _____

City, State, Zip Code: _____

Phone: _____

This authorization is a two-way authorization and shall authorize both named parties above to exchange the protected health information stated below between each other: ☐ Yes ☐ No

SIGNATURES

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)

This consent is subject to revocation at any time except to the extent that any other lawful holder of patient identifying information that is permitted to make the disclosure has already acted in reliance on it.

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.

I understand that my substance use disorder records are protected under the Federal Regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

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. 11/2020