



AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

**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 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.



MRN: _____ Facility Use Only

Authorization: I request a copy of my records or 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: ____/____/____

Last 4 digits of Social Security Number: _____ Telephone: () _____

- Record Holder:**
- | | |
|---|--|
| <input type="checkbox"/> Scripps Clinic | <input type="checkbox"/> Scripps Coastal Medical Center |
| <input type="checkbox"/> Scripps Green Hospital | <input type="checkbox"/> Scripps Memorial Hospital Encinitas |
| <input type="checkbox"/> Scripps Memorial Hospital La Jolla | <input type="checkbox"/> Scripps Mercy Hospital Chula Vista |
| <input type="checkbox"/> Scripps Mercy Hospital San Diego | |

Other record holder: Name: _____
Address: _____

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:

- | | |
|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> History/Physical Exam | <input type="checkbox"/> Laboratory Tests |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> X-ray reports |
| <input type="checkbox"/> Operative/Procedure Reports | <input type="checkbox"/> Photographs, videotapes, digital or other images |
| <input type="checkbox"/> Emergency Department Reports | <input type="checkbox"/> 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: _____



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