Authorization of Release

Use & Disclosure of Protected Health Information
Medicare Third Party Liability (TPL)

IEHP A Publi I DualChoice

The federal HIPAA Privacy Regulations require that this Authorization be completed to authorize Inland Empire Health Plan (IEHP) to use or 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***

Request for Claims/Billing

Enter the date of injury for PHI records needed: ____/____/____

Please indicate the type of injury:

- ☐ Auto Accident
- ☐ Personal Injury
- ☐ Workers Comp
- ☐ Other _____

The PHI records will be used and disclosed for the following purpose(s):

_____

RECORD DELIVERY — ***REQUIRED***

Delivery Options: (please check one)

- ☐ Pick Up at IEHP
- ☐ Certified Mail
  Delivery Address _____
- ☐ Secure E-mail Portal
  E-mail Address _____

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)*

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 HIV diagnoses and prescriptions, psychiatric/mental health conditions, or alcohol/drug/substance abuse 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:

☐ Alcohol/drug/substance abuse records ☐ HIV-related records

☐ Psychiatric/mental health records ☐ Other _____

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 revocation is 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 onsite.

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

Please complete, sign, and return this Authorization to IEHP:

Inland Empire Health Plan | attn: Claims Audit & Recovery
10801 Sixth Street, Suite 120, Rancho Cucamonga, CA 91730
Phone: 1-877-273-4347 | TTY: 1-800-718-4347
Email: TPL@iehp.org | Fax: (909)296-3636