Release of Protected Health Information (PHI)

Use & Disclosure of Protected Health Information

Inland Empire Health Plan

HIPAA, federal regulations and California law require that this release 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

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

☐ 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 health care service(s) i.e., Primary Care Physicians, Specialists, Hospitals, etc.

Please check the box(es) below if you want this release to include the following record(s). If you do not check, then the record(s) with this information will be excluded.

☐ Substance Use Disorder
☐ HIV Test Results and Treatment Information
☐ Mental Health Treatment Information *(does NOT include psychotherapy notes)*
☐ Other Sensitive Services*
*"Sensitive services" include sexual and reproductive health care, mental health, sexual assault counseling and care, gender-affirming care, domestic violence care, and alcohol and drug use treatment (California Civil Code § 56.05).

RECORD DELIVERY

REQUIRED

Delivery Options: (please check one)

☐ FedEx Delivery (No fee to member): No P.O. Box available
Delivery Address _____

☐ Secure Email Portal*
Email Address _____

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

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AUTHORIZATION

REQUIRED

I hereby authorize IEHP to release records to: _____
Name of Person or Entity

_____ _____
Address: City, State, Zip Code:

_____
Phone:

SIGNATURES

REQUIRED

I read this release 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 documenatation 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 release 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 release. 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 release 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 release 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 release to disclose it, unless a new release 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 release 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 release to:

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