Scripps

Request to Obtain a Copy of or Inspect Your Health Information

Your Right. You have the right to inspect or obtain a copy of your health information with limited exceptions. Please be aware that your original medical record is a Scripps legal record and under no circumstances are we able to delete or remove information from your record.

How do I get a copy of my medical information? At Scripps, we respect your right and have developed procedures and processes so that you are able to obtain a copy of your medical information. Your request must be in writing and include the elements on the attached form, *Authorization for Use or Disclosure of Health Information.* Our Health Information Department will receive your request. Requests to inspect your information will be processed within five (5) working days. Requests for copies of your information will be processed within fifteen (15) calendar days of receiving your request. If we require additional time for processing your request, we will notify you and request an extension. This may be necessary if your records are stored in an offsite location or if you have recently been discharged from the hospital.

How do I inspect my medical records? If you are requesting to inspect your health information, an appointment will be scheduled during the business hours 8 AM to 4 PM of the Health Information Department.

Will I have to pay for copies of my medical records? The Health Information Department will inform you of the fees associated with your request. Additional fees may be charged if your request requires copies of film or video. In limited circumstances, where your records are being requested to support an appeal regarding eligibility for a public benefit program, your copies will be provided at no cost.

Questions and Assistance

If you have questions or specific concerns, please contact the Health Information Department where your services were provided:

- Scripps Clinic (Scripps Medical Foundation): (858) 554-8545
- Scripps Coastal Medical Center (Scripps Medical Foundation): (760) 806-5633
- Scripps Green Hospital: (858) 554-4700
- Scripps Home Health: (858) 715-7378
- Memorial Hospital Encinitas: (760) 633-7746
- Scripps Memorial Hospital La Jolla: (858) 626-6850
- Scripps Mercy Hospital Chula Vista: (619) 691-7336
- Scripps Mercy Hospital San Diego: (619) 260-7286

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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.**

AUTHORIZATIONTO 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.

Please initial that you have read the above statements:_____

Printed Name Initials

Complete page 2 of this form

100-8700-739SW (Rev. 1/17/12)

Scripps

MRN: _____
Facility Use Only

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:

Patient Name: _____ Also known as: _____

Date Of Birth: ____/____/____ Telephone: ( ) _____

Last 4 digits of Social Security Number: _____

Record Holder:

☐ Scripps Clinic ☐ Scripps Coastal Medical Center

☐ Scripps Hospital Name: _____

☐ Scripps Home Health

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:

☐ Discharge Summary
☐ History/Physical Exam
☐ Consultation Reports
☐ Operative/Procedure Reports
☐ Emergency Department Reports
☐ Progress Notes
☐ Laboratory Tests
☐ X-ray reports
☐ Photographs, videotapes, digital or other images
☐ Other (please specify):_____

Acknowledgment to include specific 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** ☐ **Mental Health**
☐ **Alcohol and/or drug abuse program 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): _____

Signature:_____ Date: _____

3ROI

WHITE - Medical Record Copy YELLOW - Requestor Copy 100-8700-739SW (Rev. 1/17/12)