SCOTT&WHITE
HEALTH PLAN

Customer Service Authorization for Release of Information

Scott & White Health Plan is required by the HIPAA privacy law to receive authorization before releasing individual private health information. The contract holder/member may sign & check the information to be released. For minors, if someone other than a parent or legal guardian is the contract holder, the parent or legal guardian should sign and check the information to be released.

I hereby authorize the following information to be released from the record of:

Member's Name:______________________________________ DOB: ________________
Member'sID #s ________________
Address: ____
City: ______________________ State: ________ Zip:__________
Telephone #: (__)______________________

PLEASE CHECK INFORMATION TO BE RELEASED

___ Billing/ Premium Information
___ Application /Eligibility Information
___ Claims information for Customer Service (verbal information only)
___ General Benefits
___ Benefits Determinations/ Prior Approvals (verbal information only)
___ Other (specify) ____

Member's SS #: (optional)________________

Please list who this information is to be released.
TO:

____ Relationship:________________
Address: ____
City: ______________________ State: ________ Zip:__________

FROM: Scott and White Health Plan, 2401 S. 31st St., Temple, TX 76508

I understand that to the extent any Recipient of this information, as identified above, is not a "covered entity" under Federal or Texas Privacy law, the information may no longer be protected by Federal and Texas Privacy law once it is disclosed to the Recipient and, therefore, may be subject to re-disclosure by the Recipient.

I understand that I may revoke this authorization in writing at any time except to the extent that Scott and White Health Plan has already relied on this authorization. I understand that I may revoke this authorization by providing Scott and White Health Plan a written request for revocation stating my intent to revoke this authorization.

This authorization will expire upon the earlier of 12 months from date of signature, or the date or event specified here:
______________________________.

I understand that the information released is for the specific purpose stated below and may not be provided in whole or in part to any other agency, organization, or person.

Purpose of Disclosure:
Attorney/Legal ___ Personal Use (at the request of the individual) ___ Other (specify) ____________________
____

______________________________ ______________________
Printed Name of Enrollee or Legal Representative   Relationship to Enrollee

______________________________ ______________________
Signature of Enrollee or Legal Representative   Date

*****This release would not meet the requirements for HSD, SRCARE, or Claims Release of Information***** ***6/27/08 sk***