Baylor Scott & White Health Plan

Scott & White HEALTH PLAN — PART OF BAYLOR SCOTT & WHITE HEALTH

FirstCare HEALTH PLANS — PART OF BAYLOR SCOTT & WHITE HEALTH

AUTHORIZATION FOR RELEASE OF HEALTH PLAN INFORMATION

I hereby authorize Scott and White Health Plan d/b/a Baylor Scott & White Health Plan, and its subsidiaries SHA, LLC d/b/a FirstCare Health Plans, Scott & White Care Plans d/b/a Baylor Scott & White Care Plan, and Baylor Scott & White Insurance Company, (collectively referred to as BSWHP), to discuss **and** release my personal medical health information, as applicable, in writing, in person, and/or by telephone, with the following individuals and for the following purposes:

Initial if applicable:______Alcohol/Drug _____ Genetics _____ HIV/AIDS_____ Mental Health
Check All that Apply:

❑ General Benefit Information	❑ Claims Information	❑ Demographic Changes	❑ Authorization/Referrals
❑ Billing/Premium	❑ Appointment Assistance	❑ Application/Eligibility	❑ Material Requests
❑ Complaint/Appeals	❑ ID Cards	❑ Other ________________________________	

I understand this authorization is voluntary and I may refuse to sign this authorization. I further understand that my healthcare and the payment of my healthcare will not be affected if I do not sign this form. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-healthcare provider, the released information may no longer be protected by federal and state privacy regulations.

I further understand that I may revoke this authorization at any time by sending a written statement of revocation to Baylor Scott & White Health – Office of Corporate Compliance, Office of Corporate Compliance, 2401 S. 31st Street, MS-AR-300, Temple, Texas 76508. I also understand the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.

This document will expire upon revocation, or at the date or event specified here ________________________.

Member Name		Date of Birth MM/DD/YYYY
Street Address	City, State, ZIP	Telephone Number

The information will be released to:

Individual/Organization Name		Telephone Number
Street Address	City, State, ZIP	Fax Number
Individual/Organization Name		Telephone Number
Street Address	City, State, ZIP	Fax Number

Purpose of the use and/or disclosure: ❑ Continued Care ❑ Legal ❑ Insurance ❑ Personal Use ❑ Other ______________________
Record copy format: ❑ Paper ❑ CD ❑ ____________________ **Record copy delivery:** ❑ Pick-up ❑ Mail ❑ Fax to healthcare office

I understand that this document applies to all departments, healthcare providers and/or employees with BSWHP.

Signature of Member/Legal Representative (electronic signature not accepted) ______________ Date ______________

Printed Name of Member/Legal Representative ______________ Relationship to Member ______________

Representative's Authority to Act for Member (attach supporting documentation) ______________

Please return the completed form by mail or fax.

Mail: Attn: Customer Advocacy
1206 W. Campus Drive, Temple, TX 76502
Fax: 254.298.3663

Phone: General: 844.633.5325; TTY: 711
RightCare: 855.897.4448 (855.TX.RIGHT)
FirstCare Marketplace: 855.572.7238