FirstCare HEALTH PLANS
PART OF BAYLOR SCOTT & WHITE HEALTH

AUTHORIZATION FOR RELEASE OF HEALTH PLAN INFORMATION

I hereby authorize Scott and White Health Plan and its subsidiaries, including SHA, LLC d/b/a FirstCare Health Plans, Scott & White Care Plans, Insurance Company of Scott and White, and Southwest Life & Health Insurance Company, (collectively referred to as "SWHP"), 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:

Check All that Apply:
Include this information if applicable: _____ Alcohol/Drug (MBR INITIALS) **_____ Genetics** (MBR INITIALS) **_____ HIV/AIDS** (MBR INITIALS) **_____ Mental Health** (MBR INITIALS)

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

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care 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-health care 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, TX 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 SWHP.

_____ _____
Signature of Member or Legal Representative (electronic signatures not acceptable) Date

_____ _____
Printed Name of Member or Legal Representative Relationship to Member

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

Please return the completed form via mail or fax.

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

Fax: 254-298-3663
Phone: 800-884-4901