Scripius

Scripius® members:
P.O. Box 30192
Salt Lake City, UT 84130-0192
Phone: 800-442-3127
Fax: 801-442-6580
scripius.org

Authorization to Release Health Information

Form is not valid unless fully completed. Please return with a photocopy of the signer's government–issued photo ID.

I understand the following information:

1. Once Scripius releases information according to this authorization, Scripius cannot guarantee that this information will not be re-released to a third party or that this information will be protected by federal and state law governing the use and disclosure of identifiable health information.
2. This authorization will remain in effect until it expires or until I revoke it in writing.
3. I may refuse to sign or may revoke this authorization at any time for any reason, unless Scripius has already made disclosures in reliance on this authorization.
4. While Scripius does not condition the beginning, continuation, or quality of health insurance, care management, and other services it provides to me based on this authorization, refusing to sign or revoking this authorization may limit Scripius's ability to provide such services to me.

In understanding the above, I agree to let Scripius share my information as described in this form. Questions? Call: **800-442-4127**. TTY users may call **711**.

Member Information

First Name _____ Last Name _____

Member ID (on ID Card) _____ Street Address _____

City _____ State _____ ZIP _____

Ph# (_____) _____ Date of Birth _____ /_____ /_____
MM DD YYYY

cut here.

Scripius may share information about the Scripius member named above (check one):

☐ For one year from the signature date ☐ For the length of the policy ☐ Until this date _____ /_____ /_____
MM DD YYYY

NOTE: *If an expiration date is not indicated, this authorization will stay active until one year from the signature date.*

The member's information may be shared with the following person or organization *(only one person or organization per form):*

Name of person or organization _____ Date of Birth *(if person)* _____ /_____ /_____
MM DD YYYY

Street Address _____ Ph# (_____) _____

City _____ State _____ ZIP _____

Type of information to be shared (check the box(es) below to choose which information you would like shared).

☐ Enrollment ☐ Existing appeal information ☐ All of the above
☐ Contact ☐ Care management ☐ Other _____
☐ Existing prior authorization ☐ Claims payment

SIGNATURE

_____ _____
Signature of member or legal representative — Description of legal representative's authority (Verification may be requested)

Date _____ /_____ /_____ ☐ **I have included a photocopy of the signer's government-issued photo ID.**
MM DD YYYY

SCRIPIUS USE ONLY: ATTENTION MEMBER SERVICES

Password _____

Security question _____

Security question answer _____

Select Health and Select Health Benefit Assurance Company, Inc. (doing business as “Scripius”) obey federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

This information is available for free in other languages and alternate formats by contacting:

Select Health Medicare: **855-442-9900** (TTY: 711) / Scripius: **800-442-3127** / Select Health: **800-538-5038**

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電