# Authorization to Share Personal Health Information

VERIFY CURRENT INFORMATION (please print)

Date of Request: _____

Member Name: _____ Date of Birth: _____

Care1st #: _____ Phone #: _____

Address: Street _____ City/State _____ Zip _____

## Your Request

Are you the member? ☐ Yes ☐ No

If you answered "No", please tell us who you are:

☐ The member's mother, father, legal guardian, etc.

☐ I make health decisions for the member as his/her authorized representative

☐ The member died and I take care of the assets

Name of Requestor (fill out if you are **not** the member – please print): _____

**I would like Care1st Health Plan Arizona to share my personal health information, including claim and/or benefit information, to:**

(Recipient's Name – Please Print) _____

**This information may contain specific treatment or services I have received. This information may include information created by others.**

**This Authorization to Share Personal Information allows Care1st Health Plan Arizona, on behalf of itself and related companies, to discuss or give out your personal health information to a person you select. The Health Insurance Portability and Accountability Act (HIPAA) requires us to get your permission before we release your information.**

By placing my initials in front of any of the following items, I specifically authorize Care1st to disclose, or share, the following (NOTE: FEDERAL REGULATIONS REQUIRE A DESCRIPTION OF THE REASONS FOR DISCLOSING SUBSTANCE ABUSE INFORMATION):

_____ HIV/AIDS and communicable disease-related records

_____ Mental Health records

_____ Genetic testing records

_____ Drug/alcohol treatment for the following reasons:

_____

_____

*Go to next page*

**By signing this Authorization, I understand that:**

- Care1st will disclose, or share, information that may contain Protected Health Information (PHI) to the person I described in this request.
- This permission is voluntary. I may change or revoke (cancel) this request in writing at any time (please mail your written request to change or revoke to the address below).
- My request will not be processed if this form is not completely filled out, signed and dated.
- I may refuse to sign this authorization, and my refusal will not affect my eligibility for benefits.
- If I do not understand this form, or have any questions about this form, I may contact Care1st at: **1-866-560-4042** (TTY **711**).
- **This authorization will end in twelve (12) months from the date of my signature unless otherwise noted below:**

**I want the authorization to end on (list date):**

_____

Member Signature (or authorized representative, Date or legal guardian)

If you signed and are not the Member, what is your phone number? Please provide below:

_____

*Note: Before Care1st can consider a request signed by anyone other than the member, we require verification of a person's authority to act on behalf of the member (if not already on file). If member cannot give consent due to age, Care1st may require additional information before we can consider this request.*

Enclosed is a stamped, self-addressed envelope to send the Release of Information back after you have reviewed and signed the forms.

**Return this form to:**

Care1st Health Plan Arizona

Attn: Privacy Officer

PO Box 52079

Phoenix, AZ 85072-9686

**Please note:** This authorization does not allow the person/entity named above to change the plan you are enrolled in, to represent you in an appeal, or to make any of your treatment decisions or direct care decisions. If you want someone to make health care and treatment decisions on your behalf, you will need additional legal documentation and will be required to submit a different form.

This form does not allow Care1st to release medical records on file to the person/entity named above. If you want Care1st to release medical records, please fill out the "Authorization to Release Record of PHI" form.

Revised 03/2022

CARE1ST HEALTH PLAN ARIZONA

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