Authorization to Release Record of Protected Health Information (PHI)

VERIFY CURRENT INFORMATION (please print)

Date of Request: _____

Member Name: _____ Date of Birth: _____

Care 1st ID#: _____ 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 release my health record because (check all that apply):

☐ To help with the coordination of health care

☐ For worker's compensation claims

☐ For coverage or payment reasons

☐ Other (please explain): _____

☐ This disclosure is being made at my request and I choose not to state the reason for this disclosure

Unless otherwise indicated, my authorization includes claim data, pharmacy claim data, prior authorization requests and grievance and appeals data. Note: if you wish to grant limited access (for example, specific dates of service), please specify that in the space provided below:

_____

_____

By placing my initials in front of any of the following items, I specifically authorize Care1st to disclose 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:

_____

_____

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How you would like to receive your response:

☐ I would like to receive copies of PHI to be sent electronically as a PDF (we will contact you to set up the process so you can receive electronic information in a **secure** way).

Print your email address:_____OR enter your mailing address below (if different than address you listed on the previous page):

_____ Attn: _____

_____

☐ I would like it faxed to the following number. Fax #:_____Attn: _____

☐ I would like to come in and see a copy of my PHI that Care1st has on file.

☐ I would like a paper copy of my PHI mailed to the following address/person (if different than above):

_____ Attn: _____

_____

☐ I want another person to pick up my information (enter their Name): _____

By signing this Authorization, I understand that:

- Care1st will send information that contain PHI to the address or means I described in this request.
- 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.
- I may inspect or copy any information to be disclosed under this authorization.
- If I do not understand this form, or have any questions about this form, I may contact Care1st at: 1-866-560-4042 (TTY 1-800-367-8939).
- **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, or legal guardian) Date

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.

Return this form to:

Care1st Health Plan Arizona
Attn: Privacy Officer
1850 W Rio Salado Parkway Ste 211
Tempe, AZ 85281