ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Authorization To Disclose Protected Health Information To AHCCCS

Attention ALTCS Customer:

Please complete the “Authorization to Disclose Protected Health Information to AHCCCS” form.
A signature on the form is required by one of the following people:

- Customer;
- Customer’s parent if the customer is under the age of 18; or
- Customer’s Legal Guardian or Legal Representative. Copy of court documents must be provided.

Return this completed form using one of the return options below. For any questions, call (602) 417-6600 or toll-free (888) 621-6880. Please note, returning this form quickly will allow us to assist in getting medical documentation for your application.

Return Options:
Fax (toll-free): 888-507-3313
E-mail: altcsregistration@azahcccs.gov
Mail: AHCCCS
801 E Jefferson St
MD 3900
Phoenix AZ 85034

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Authorization To Disclose Protected Health Information To AHCCCS

Customer Name:	Date of Birth:
AHCCCS PID:	Date of Request:
Customer Mailing Address:	Social Security Number (SSN): (SSN is optional but may help the provider locate records)

For use by AHCCCS customers/applicants who want a doctor or other entity to give AHCCCS their protected health information.

I give my permission for any health care provider to disclose any of my protected health information to AHCCCS, for the purpose of determining my eligibility for any of the publicly funded programs administered by AHCCCS. I give AHCCCS permission to share this information with the Arizona Department of Economic Security, Disability Determination Services Administration, if necessary, to determine my disability status.

In addition, by checking these boxes, I specifically authorize the disclosure of the following types of records:	
Medical Records	
☐	HIV/AIDS and communicable disease related information and/or records
☐	Mental health information and/or records
☐	Genetic testing information and/or records
☐	Alcohol and drugs screening information and/or records
School Records	
☐	Educational and evaluation records

By signing this Authorization, I understand that:

- AHCCCS is required by state and federal law to keep confidential the information described above and may only use or disclose that information with my approval, for purposes directly related to the administration of the AHCCCS program, or as otherwise permitted or required by law.

- I understand that if I revoke this authorization or refuse to sign, AHCCCS may not be able to determine my current or future eligibility for the publicly funded medical assistance programs administered by AHCCCS. As a result, my application for assistance may be denied or the assistance may be discontinued.

- I also understand that the information will not be used for any prohibited purposes such as health oversight activities, judicial and administrative proceedings, law enforcement purposes, or disclosures to coroners and medical examiners.

- I may **revoke** this authorization at any time, in writing, by phone, or fax by completing an AHCCCS "Revocation of Authorization" form, and sending it to:

  Arizona Health Care Cost Containment System
  Office of the General Counsel
  Attention: Privacy Officer
  801 E Jefferson St, MD 6200
  PO Box 25520
  Phoenix AZ 85034
  Phone 602-417-4455
  Fax 1-602-253-9115

Once AHCCCS receives the revocation, this authorization will be revoked, except to the extent that AHCCCS has already taken action in reliance upon this authorization.

By checking the box below, I revoke this authorization upon the following date or event.

This authorization will expire on:		
☐	Insert specific date:	_____
☐	Insert specific event:	_____

The customer's signature is required to get medical records. If the customer is under the age of 18, the signature of the customer's parent is needed. If the customer has a legal guardian or legal representative, the signature of the legal guardian or legal representative is needed.

Signature:	Date:
Printed name of person signing form:	Relationship to Customer:
Printed name of witness (only needed if customer signed with mark):	Signature of witness:

AHCCCS will not pay for medical records per Arizona Administrative Code R9-22-512.E.

Return Information to: AHCCCS 801 E Jefferson St MD 3900 Phoenix AZ 85034 Fax: 888-507-3313	AHCCCS Worker Name:
	E-mail:
	Phone Number: