

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

CUSTOMER:

DATE:

HEAPLUS PERSON ID:

APPLICATION ID:

ADDRESS:

Call if you have any questions or need help.

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

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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

Email: altcsregistration@azahcccs.gov

Mail:

AHCCCS

P.O. Box 6050

MD 15023

Phoenix, AZ 85002-5520

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO AHCCCS

Return Information to:

AHCCCS

P.O. Box 6050 MD 15023

Phoenix, AZ 85002-5520

Fax: 888-507-3313

AHCCCS Worker Name:

Email:

Phone Number:

Customer Name:

Date of Birth:

Customer Address:

PID:

Date of Request:

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 medical records:

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- 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

If the information to be disclosed comes from a school, please fill out this box:

- I specifically authorize the holder of my information to disclose all of my educational and evaluation records in its possession to AHCCCS.

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 refuse to sign or revoke this authorization, 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 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:

AHCCCS - Office of the General Counsel
Attention: Privacy Officer
P.O. Box 6050
MD 15013
Phoenix, AZ 85002-5520
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.

I may revoke this authorization upon a certain date, event, or both by completing the selection below. If I do not specify a date or event, this authorization will remain active for 1 year from the date of signature unless AHCCCS is notified that this authorization is revoked.

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

P.O. Box 6050 MD 15023

Phoenix AZ 85002-5520

Fax: 888-507-3313

AHCCCS Worker Name:

E-mail:

Phone Number: