AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO AHCCCS

Return Information to:

AHCCCS
801 E. Jefferson St. MD 3900
Phoenix, AZ 85034
Fax: 888-507-3313

AHCCCS Worker Name:

Email:

Phone Number:

Customer Name:

Date of Birth:

Customer Address:

AHCCCS ID Number or 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:

☐ HIV/AIDS and communicable disease related information and/or records

☐ Mental health information and/or records

☐ Genetic testing 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 also 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, in writing, at any time, by completing an AHCCCS "Revocation of Authorization" form, and sending it to:

Arizona Health Care Cost Containment System
Office of Legal Assistance
Attention: Privacy Officer
701 E. Jefferson, MD 6200
Phoenix, AZ 85034
Phone 602-417-4232
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.

Please choose one of the following:
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: