Authorization to Disclose Protected Health Information by AHCCCS

(For use by AHCCCS members who want AHCCCS to disclose their protected health information to another person/entity)

Name:	AHCCCS ID Number or ACN:
Address:	
Date of Request:	Date of Birth:

I give my permission for AHCCCS to disclose my protected health information to:

Name of Person or Entity and Address:

_____

_____

_____

*You **MUST** choose one of the following:*

☐ I specifically authorize AHCCCS to disclose **all** of my protected health information in its possession to the person/entity listed above.

☐ I specifically authorize AHCCCS to disclose **only the health information described here**:

_____

_____

*You **MUST** choose one of the following:*

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

☐ I specifically authorize the disclosure of my health information for the following purpose(s):

_____

By placing my initials in front of any of the following items, I specifically authorize AHCCCS to disclose the following: [NOTE: FEDERAL REGULATIONS REQUIRE A DESCRIPTION OF THE REASONS FOR DISCLOSING SUBSTANCE ABUSE INFORMATION.]

_____ HIV/AIDS and communicable disease related information and/or records
_____ Mental health information and/or records
_____ Genetic testing information and/or records
_____ Drug/alcohol diagnosis, treatment/referral information for the following purposes:

_____

_____

By signing this Authorization, I understand that:

- I may refuse to sign this authorization, and my refusal will not affect my eligibility for benefits. If I do not sign this form, my health care and the payment for my health care will not be affected.
- If the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed again by that person or entity, and your information will no longer be protected by the regulations. However, the Federal Substance Abuse Confidentiality Requirements may prohibit any further disclosure.
- I may see and obtain a copy of the information on this form, per AHCCCS policy, if I ask for it.
- I may decide at any time that I do not want to do this. I must then **revoke** this authorization **in writing**. If I do, it will not have any effect on the actions taken before the revocation of my authorization. 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. Revocations can be made by completing an AHCCCS "Revocation of Authorization" form, and sending it to:

  Arizona Health Care Cost Containment System
  Office of Administrative Legal Services, Attention: Privacy Officer
  701 E. Jefferson, MD 6200
  Phoenix, AZ 85034
  Fax 1-602-253-9115

I have read the above and authorize the disclosure of the protected health information as stated. This authorization will expire one year from date of signing unless another date or specific event is given:

Specify other expiration date/event: _____

Signature of Member or Legal Representative:	Date:
Print Name of Member or Member's Legal Representative:	Relationship to Member:
For AHCCCS use only: Received by _____	Date of Receipt _____