AHCCCS

Authorization To Disclose Protected Health Information to AHCCCS

(For use by AHCCCS members/applicants who want a doctor or other entity to give AHCCCS their protected health information)

Name:	AHCCCS ID Number or ACN:
Date of Request:	Date of Birth:
Address:	SSN (optional, could assist the health care provider in locating records)

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.

If the information to be disclosed comes from any federally assisted substance abuse program, please fill out this box:

NOTE: FEDERAL REGULATIONS REQUIRE A DESCRIPTION OF THE REASONS FOR DISCLOSING SUBSTANCE ABUSE INFORMATION.

☐ I specifically authorize any health care provider to disclose my protected health information from any federally-assisted substance abuse program to AHCCCS for the following purpose(s): _____

_____

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. However, AHCCCS is prohibited from disclosing to any other person, without my written permission, substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

- 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: _____

Member or Member's Representative

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

Unless revoked earlier, this authorization will expire when my application for assistance through AHCCCS is withdrawn, denied, or when my eligibility for assistance through AHCCCS ends. However, this authorization will continue during any time while I am contesting my eligibility in an administrative hearing or court proceeding.