

Authorization to Release Record of Protected Health Information (PHI)

VERIFY CURRENT INFORMATION (please print)

Date of Request: _____
Member Name: _____ Date of Birth: _____
Care 1st or ONECare ID#: _____ Phone #: _____
Address: _____
Street City/State Zip

YOUR REQUEST

Are you the member? If you answered "No", please tell us who you are:
 Yes No The member's mother, father, legal guardian, etc.
 I make health decisions for the member as his/her authorized representative
 The member died and I take care of the assets

Name of Requestor (fill out if you are **not** the member – please print): _____

I would like ONECare/Care1st Health Plan Arizona to release my health record because (check all that apply):

- To help with the coordination of health care
- For worker's compensation claims
- For coverage or payment reasons
- Other (please explain): _____
- This disclosure is being made at my request and I choose not to state the reason for this disclosure

Unless otherwise indicated, my authorization includes claim data, pharmacy claim data, prior authorization requests and grievance and appeals data. Note: if you wish to grant limited access (for example, specific dates of service), please specify that in the space provided below:

By placing my initials in front of any of the following items, I specifically authorize Care1st to disclose the following (NOTE: FEDERAL REGULATIONS REQUIRE A DESCRIPTION OF THE REASONS FOR DISCLOSING SUBSTANCE ABUSE INFORMATION):

- _____ HIV/AIDS and communicable disease-related records
- _____ Mental Health records
- _____ Genetic testing records
- _____ Drug/alcohol treatment for the following reasons:

How you would like to receive your response:

I would like to receive copies of PHI to be sent electronically as a PDF (we will contact you to set up the process so you can receive electronic information in a **secure** way).

Print your email address: _____ OR enter your mailing address below (if different than address you listed on the previous page):

_____ Attn: _____

I would like it faxed to the following number. Fax #: _____ Attn: _____

I would like to come in and see a copy of my PHI that Care1st has on file.

I would like a paper copy of my PHI mailed to the following address/person (if different than above):

_____ Attn: _____

I want another person to pick up my information (enter their Name): _____

By signing this Authorization, I understand that:

- Care1st will send information that contain PHI to the address or means I described in this request.
- I may change or revoke (cancel) this request in writing at any time (please mail your written request to change or revoke to the address below).
- My request will not be processed if this form is not completely filled out, signed and dated.
- I may refuse to sign this authorization, and my refusal will not affect my eligibility for benefits.
- I may inspect or copy any information to be disclosed under this authorization.
- If I do not understand this form, or have any questions about this form, I may contact Care1st at: 1-866-560-4042 (TTY 1-800-367-8939).
- **This authorization will end in twelve (12) months from the date of my signature unless otherwise noted below:**

I want the authorization to end on (list date): _____

Member Signature (or authorized representative,
or legal guardian)

Date

If you signed and are not the Member, what is your phone number? Please provide below:

Note: Before Care1st can consider a request signed by anyone other than the member, we require verification of a person's authority to act on behalf of the member (if not already on file). If member cannot give consent due to age, Care1st may require additional information before we can consider this request.

Return this form to:

Care1st and ONECare by Care1st Health Plan Arizona

Attn: Privacy Officer

432 North 44th Street, Ste 300

Phoenix, AZ 85008