



Authorization to Release Protected Health Information (PHI)

Protected Health Information (PHI) means information about your health. Federal and state laws protect the privacy of your PHI. By signing this paper, you give us your **OK**. We will only give out the PHI that you say we can share. And, we will only give it to the people or agencies that you list.

1. Who is the Medicaid Member?

First name	Last name	Middle initial
Member ID number	Birth date (MM/DD/YYYY)	Phone number
Street		
City, state, ZIP code		

2. Who can the PHI be given to?

Person or company name	Phone number
Street	
City, state and ZIP code	
Person or company name	Phone number
Street	
City, state and ZIP code	
Person or company name	Phone number
Street	
City, state and ZIP code	
Person or company name	Phone number
Street	
City, state and ZIP code	

"Mercy Care" also includes Mercy Care's subsidiaries, affiliates, employees, agents and subcontractors.

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3. What PHI can we share?

We will **only** share the PHI that you **OK**. Tell us the type of PHI by checking the box.

- Any information requested Health (medical, dental, pharmacy, vision)
 Long term care Patient management records

Sensitive Information: (this information may include diagnosis and/or treatment information)

- Substance use disorder (alcohol/drug) HIV/AIDS Sexually transmitted diseases
 Behavioral health/Mental health (but NOT psychotherapy notes).
 Other (please explain) _____

4. Why are you giving out this PHI?

Reason/Purpose:

5. This form is good for 1 year unless you give a shorter time below.

My OK is good from:

_____ to _____
MM/DD/YYYY MM/DD/YYYY

By signing below, I understand and agree:

- I can take back my **OK** by writing to the address on this form.
- If you take back your **OK** it won't take back the PHI we already shared. But we will not share any more of your PHI.
- My chance to sign up for insurance will not change if I don't sign this form.
- Whoever gets my PHI may share it with others. That means laws may not be able to protect my PHI.
- The PHI I **OK** to share may include:
 - Health condition and treatment information
 - Chronic diseases
 - Behavioral/Mental health conditions
 - Substance use disorder diagnosis or treatment (alcohol/drug)
 - Transmissible diseases, sexually transmitted diseases (HIV/AIDS), and genetic marker information
- I can get a copy of this **OK** by writing to the address on this form.
- Mercy Care will not share my PHI with whom I named unless I sign this form, and not with anyone else.

ATTENTION:

I must sign this form if any of the options below apply.

- I am 18 years of age or older.
- I am under 18 years of age and I am married or emancipated.
- My state allows me to be treated even if my parents or legal guardian do not agree.
- My PHI being shared may include one or more of the below conditions:
 - Behavioral/Mental health conditions
 - Substance use disorder diagnosis or treatment (alcohol/drug)
 - Sexually transmitted disease (including HIV/AIDS)
 - Reproductive health (including contraception, prenatal care and abortion)

6. Signature of Member or Authorized Representative.

Signature	Date
Print name	
If a legal representative signed this form, describe the relationship: (parent, legal guardian, Power of Attorney, personal representative)	

Authorized Representative means you have legal proof that you can act for this person. A representative signs for a person who cannot legally sign on his or her own. If the member is less than 18 years old, a parent, or guardian should sign for the minor. If you are a representative, signing this form you must send legal proof you can act for this person.

Do you have questions? We can help. **Call Mercy Care at 800-624-3879.**

Please sign and return this completed form to: **Mercy Care**
Member Services
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

Nondiscrimination Notice

Mercy Care complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Mercy Care does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Mercy Care:

- Provides no-cost aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides no-cost language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card or **1-800-385-4104 (TTY:711)**.

If you believe that Mercy Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our Civil Rights Coordinator at:

Address: Attn: Civil Rights Coordinator
4500 East Cotton Center Boulevard Phoenix,
AZ 85040
Telephone: **1-888-234-7358 (TTY 711)**
Email: **MedicaidCRCoordinator@MercyCareAZ.org**

You can file a grievance in person or by mail or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

