Mercy Care
Phone: 602-586-1841 or 1-800-564-5465
TTY/TDD: 711
Fax: 1-844-424-3975

mercy care

Consent 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. The laws say we cannot give anyone, other than your doctors and others who may be taking care of you, your PHI unless you say it is OK. By signing this paper, you give us your OK. We will only give out the PHI that you say we can share. Also, we will only give it to people or agencies that you list. If you have any questions or need help, call Mercy Care at 602-586-1841 or 1-800-564-5465; (TTY/TDD) 711.

Who is the member?

Last Name	First Name	Middle Initial
AHCCCS ID Number	Date of Birth	Phone
Address	State	Zip Code

Check One

☐ I am the member

☐ I have the legal right to act for this person (Check one below. If "other," fill in the blank)

I am his/her ☐ Parent ☐ Guardian ☐ Other_____

Who can PHI be given to?

Name (a person, like family members who live with me, or a place of business)	Name (a person, like family members who live with me, or a place of business)
Address	Address
Phone Number (with area code)	Phone Number (with area code)

What PHI can we share?

We will only share the PHI that you OK. Tell us the type of PHI by checking the box.
Note: Government rules (HIPAA) require a separate form to share psychotherapy notes. If you want us to share psychotherapy notes, you will need to complete a second form

☐ All PHI

OR only those checked below:

☐ HIV/AIDS/Other communicable diseas ☐ Alcohol, substance abuse information/records ☐ Treatment plans

☐ Sexual/physical/mental abuse ☐ Appeals and grievance records ☐ Medications ☐ Test/lab results

☐ Assessments/evaluation ☐ Other_____

Why are you giving out this PHI?

Tell us why you want us to share your PHI? _____

When does my OK end?

Your OK will end when you tell us it does. **Tell us when you want your OK to end.**

☐ My OK ends on this date (It cannot be more than one year from your OK): _____

OR

☐ My OK ends when this happens: _____

(It can be something like "you can share my medical records this one time only".) If you don't tell us when your OK ends, then we'lll end your OK in one year from when you sign. After one year, we will need a new OK.

Your rights and important facts

- Giving your OK is up to you. You don't have to share your information.
- You'll still get benefits and treatment even if you don't give us your OK to share your PHI.
- You can take back your OK. You must tell us in writing. Mail it to Mercy Care, 4350 E Cotton Center Blvd., Bldg. D, Phoenix, AZ 85040.
- What if you take back your OK? This will not take back the PHI that we have already shared, but we will not share any more of your PHI.
- If we share your PHI with the people or agencies that you named, they may share it with others if allowed under the law.
- HIV/AIDS and other communicable disease information cannot be shared with others unless you specifically OK them to share it or as permitted by law.
- You have a right to get a copy of this signed OK. If you need another copy, call Mercy Care at 1-800-564-5465.
- If you don't understand or have questions, we can help. Call Mercy Care at 1-800-564-5465.

Member signature

I give my OK to share the information described in this form:

_____ _____

Signature or mark of member Date

Signature of authorized representative (if any)

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

_____ _____

Signature of person signing on behalf of member Date

Printed name

Address

Witness

You should get a copy of this signed form. Remember, Protected Health Information (PHI) means any information about your health in the past, present or future. It includes facts like your address and date of birth. A full description of PHI is at 45 CFR &160.103.

Notice to anyone other than the member

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations of confidentiality of alcohol and drug abuse member records, (42 CFR, Part 2), or under state statue of confidentiality of HIV/AIDS and other communicable disease information (A.R.S. 36-664(H)) you are prohibited from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to who it pertains, or otherwise permitted by 42 CFR, Part 2 and A.R.S. 36-664(H). A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse member.