



HIPAA Authorization Form

Date: _____

Member Name: _____

Member Date of Birth: _____

Member ID #: _____

Phone Number: _____

Address: _____

Street

City, State

Zip

Are you the member? Yes No.

If "No", please tell us who you are:

- The member's mother, father, guardian, etc. Which one are you: _____
- I make health decisions for the member
- The member died and I take care of the assets

Name of requestor (not member): _____

Requester Address (not member): _____

Requester Phone Number (not member): _____

I want Care1st Health Plan to give the requester my health record because:

- I want the requester to get the information listed below
- To help with the coordination of health care
- For worker's compensation claims
- For coverage or payment reasons
- Other: _____

Please select a box:

- Care1st may give out records about: AIDS/HIV and other communicable disease, mental health information (including behavioral health and psychiatric care), alcohol/drug abuse treatment and genetic testing information.
- Care1st may not give out records about: AIDS/HIV and other communicable disease, mental health information (including behavioral health and psychiatric care), alcohol/drug abuse treatment and genetic testing information.

Please let us know what you are requesting (include dates of service, provider names, etc.)

Can you pay any fees: Yes No

How do you want to get your response:

- I want you to mail the information to the requester address listed above.
- I want you to mail me the information at the following address:

I, the member (or person acting on behalf of the member), authorize Care1st Health Plan to give out records for the member named above. I, the member (or person acting on behalf of the member), agree to the following:

- I may authorize Care1st Health Plan to use or give out member records. When I give an approval, Care1st will give out member records to a person or company.

- I know that member records cannot always be kept safe under privacy laws. I understand that a person or company that receives member records can give them out again.
- I may take back this authorization by telling Care1st Health Plan in a written letter.
- There are some times I may not be able to take back an authorization. I can contact Care1st Health Plan for more information about Notice of Privacy Practices.
- This authorization will end in twelve (12) months from the date of my signature.

I want authorization to end on : _____

The reason I want the authorization to end before twelve (12) months is: _____

I have read and I and I understand this form.
I can receive a copy of this form if I ask for a copy.

Members Name (Print)

Date

Members Signature

Member's Authorized Representative Name (Print)

Date

Member's Authorized Representative Name (Signature)

**Please send this form to:
Care1st Health Plan Arizona
Attention: Compliance Officer
2355 East Camelback Road
Suite 300
Phoenix, AZ 85016**

Please contact Care1st Health Plan Arizona at 1-866-560-4042 if you have any questions or comments.