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 ONECare by Care1st Health Plan Arizona (ONECare) 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:
☐ ONECare 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.

☐ ONECare 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 ONECare 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 ONECare to use or give out member records. When I give an approval, ONECare 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 ONECare in a written letter.
- There are some times I may not be able to take back an authorization. I can contact ONECare 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:
ONECare
Attention: Compliance Officer
2355 East Camelback Road
Suite 300
Phoenix, AZ 85016

Please contact ONECare at 1-866-560-4042 if you have any questions or comments.