arizona complete health
Complete Care Plan

Authorization to Use and Disclose Health Information

Notice to Member:

- Completing this form will allow *Arizona Complete Health-Complete Care Plan* to (i) use your health information for a particular purpose, and/or (ii) share your health information with the individual or entity that you identify on this form.

- You do not have to give permission to use or share your health information. Your services and benefits with *Arizona Complete Health-Complete Care Plan* will not change if you do not submit this form.

- If you want to cancel this authorization form, send us a written request to revoke it at the address on the bottom of this page. A revocation form can be provided to you by calling Member Services at the phone number on the back of your member ID card.

- *Arizona Complete Health-Complete Care Plan* cannot promise that the person or group you allow us to share your health information with will not share it with someone else.

- Keep a copy of all completed forms that you send to us. We can send you copies if you need them.

- If you need help, contact Member Services at the phone number on the back of your member ID card.

- Fill in all the information on this form. When finished, mail the form and any supporting documentation to

Arizona Complete Health-Complete Care Plan
ATTN: Compliance Department
1850 W. Rio Salado Parkway, Suite 211
Tempe, AZ 85281

Phone: **1-888-788-4408** (TTY/TDD: **711**)

Please read the instructions carefully and complete the form below. Incomplete forms cannot be accepted.

1 **MEMBER INFORMATION:**

Member Name (*print*): _____

Member Date of Birth: _____ Member ID Number: _____

2 **I GIVE *ARIZONA COMPLETE HEALTH-COMPLETE CARE PLAN* PERMISSION TO USE MY HEALTH INFORMATION FOR THE PURPOSE IDENTIFIED OR TO SHARE MY HEALTH INFORMATION WITH THE PERSON OR GROUP NAMED BELOW. THE PURPOSE OF THE AUTHORIZATION IS** *(check one option below):*

☐ to allow *Arizona Complete Health-Complete Care Plan* to help me with my benefits and services, **OR**

☐ to permit *Arizona Complete Health-Complete Care Plan* to use or share my health information for _____ .

3 **PERSON OR GROUP TO RECEIVE INFORMATION** *(add more Persons or Groups on next page):*

Name (person or group): _____

Address: _____

City: _____ State:_____ Zip: _____ Phone: _____

4 **I AUTHORIZE *ARIZONA COMPLETE HEALTH-COMPLETE CARE PLAN* TO USE OR SHARE THE FOLLOWING HEALTH INFORMATION:** *(NOTE: Select the first statement to release ALL health information or select the below statement to release only SOME health information. **Both CANNOT be selected**.)*

☐ **All of my health information INCLUDING:** Genetic information, services or test results; HIV/AIDS data and records; mental health data and records (but not psychotherapy notes); prescription drug/medication data and records; and drug and alcohol data and records (please specify any substance use disorder information that may be disclosed);

OR

☐ **All of my health information EXCEPT** *(check only the boxes below that apply)***:**

☐ Genetic information, services or tests

☐ AIDS or HIV data and records

☐ Mental health data and records (but not psychotherapy notes)

☐ Drug and alcohol data and records

☐ Prescription drug/medication data and records

☐ Other: _____

5 **THIS AUTHORIZATION ENDS ON THIS DATE/EVENT:** _____ *(Date this authorization ends unless cancelled. If this field is blank, the authorization expires one year from the date of the signature below.)*

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6 **MEMBER OR LEGAL REPRESENTATIVE SIGNATURE:** _____

Date: _____

IF LEGAL REPRESENTATIVE - Relationship to Member: _____

*If you are the Member's legal or personal representative, **you must send us copies of relevant forms,** such as power of attorney or order of guardianship.*

MAIL COMPLETED AUTHORIZATION FORM AND ANY SUPPORTING DOCUMENTATION TO

***Arizona Complete Health-Complete Care Plan*, ATTN: COMPLIANCE DEPARTMENT**

1850 W. Rio Salado Parkway, Suite 211 Tempe, AZ 85281

ADDITIONAL INDIVIDUAL PERSON(S) OR GROUP(S) TO RECEIVE INFORMATION:

NOTE: If you are consenting to disclose any substance use disorder records to a recipient that is neither a third party payor nor a health care provider, facility, or program where you receive services from a treating provider, such as a health insurance exchange or a research institution (hereafter, "recipient entity"), you must specify the name of an individual with whom or the entity at which you receive services from a treating provider at that recipient entity, or simply state that your substance use disorder records may be disclosed to your current and future treating providers at that recipient entity.

Name (individual or entity): ____________________

Address: ____________________

City: __________ State: __________ Zip: __________ Phone: __________

Name (individual or entity): ____________________

Address: ____________________

City: __________ State: __________ Zip: __________ Phone: __________

Name (individual or entity): ____________________

Address: ____________________

City: __________ State: __________ Zip: __________ Phone: __________

Name (individual or entity): ____________________

Address: ____________________

City: __________ State: __________ Zip: __________ Phone: __________

Name (individual or entity): ____________________

Address: ____________________

City: __________ State: __________ Zip: __________ Phone: __________

Name (individual or entity): ____________________

Address: ____________________

City: __________ State: __________ Zip: __________ Phone: __________

Name (individual or entity): ____________________

Address: ____________________

City: __________ State: __________ Zip: __________ Phone: __________

Name (individual or entity): ____________________

Address: ____________________

City: __________ State: __________ Zip: __________ Phone: __________

arizona complete health

Discrimination is Against the Law

Arizona Complete Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). Arizona Complete Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

Arizona Complete Health:

- Provides aids and services, at no cost, 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 language services, at no cost, to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages.

If you need these services, contact Member Services at:

Arizona Complete Health: **1-866-918-4450** (TTY/TDD: **711**)

If you believe that Arizona Complete Health failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with:

1557 Coordinator
PO Box 31384, Tampa, FL 33631
Phone: **1-855-577-8234** (TTY/TDD: **711**)
Fax: **1-866-388-1769**
Email: **SM_Section1557Coord@centene.com**

You can file a grievance in person, by mail, fax, or email. Your grievance must be in writing and must be submitted within 180 days of the date that the person filing the grievance becomes aware of what is believed to be discrimination.

If you need help filing a grievance, our 1557 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 at U.S. Department of Health and Human Services; 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201; or by phone: **1-800-368-1019**, **1-800-537-7697** (TTY).

Complaint forms are available at **https://www.hhs.gov/ocr/complaints/index.html**

This notice is available at the Arizona Complete Health website: **Accessibility, Privacy & Safety - azcompletehealth.com/accessibility-privacy-safety.html**

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La Discriminación es un Delito

Arizona Complete Health cumple con las leyes Federales de derechos civiles aplicables y no discrimina por motivos de raza, color de piel, nacionalidad de origen, edad, discapacidad o sexo (incluido el embarazo, la orientación sexual y la identidad de género). Arizona Complete Health no excluye a las personas ni las trata de manera diferente por su raza, color de piel, nacionalidad de origen, edad, discapacidad o sexo (incluido el embarazo, la orientación sexual y la identidad de género).

Arizona Complete Health:

- Brinda asistencia y servicios, sin costo alguno, a las personas con discapacidades para comunicarse de manera eficaz con nosotros, como los siguientes:
  - Intérpretes de lengua de señas calificados
  - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles u otros formatos)
- Brinda servicios de idiomas sin costo para las personas cuyo idioma principal no es el inglés, como los siguientes:
  - Intérpretes calificados
  - Información escrita en otros idiomas.

Si necesita estos servicios, llame a Servicios para Miembros al:

Arizona Complete Health: **1-866-918-4450** (TTY/TDD: **711**)

Si considera que Arizona Complete Health no le proporcionó estos servicios o lo discriminó de otra manera por motivos de raza, color de piel, nacionalidad de origen, edad, discapacidad o sexo (incluido el embarazo, la orientación sexual y la identidad de género), puede presentar una queja ante la siguiente entidad:

1557 Coordinator
PO Box 31384, Tampa, FL 33631
Teléfono: **1-855-577-8234** (TTY/TDD: **711**)
Fax: **1-866-388-1769**
Correo electrónico: **SM_Section1557Coord@centene.com**

Puede presentar una queja en persona, o por correo, fax o correo electrónico. La queja debe presentarse por escrito en un plazo de 180 días a partir de la fecha en que la persona que presenta la queja advierta lo que considera discriminación.

Si necesita ayuda para presentar una queja, nuestro Coordinador 1557 está disponible para ayudarlo.

También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights del U.S. Department of Health and Human Services de manera electrónica a través del Portal de Reclamos de la Office for Civil Rights, disponible en **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, o por correo postal a U.S. Department of Health and Human Services; 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201; o por teléfono: **1-800-368-1019**, **1-800-537-7697** (TTY).

Los formularios de reclamo están disponibles en **https://www.hhs.gov/ocr/complaints/index.html**

Este aviso se encuentra disponible en el sitio web de Arizona Complete Health: **Accesibilidad, Privacidad y Seguridad - azcompletehealth.com/accessibility-privacy-safety.html**

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Language assistance services, auxiliary aids and services, larger font, oral translation, and other alternative formats are available to you at no cost. To obtain this, please call **1-866-918-4450** (TTY/TDD **711**).

Spanish	Servicios de asistencia lingüística, servicios y asistencia auxiliares, letra más grande, traducción oral y otros formatos alternativos están disponibles sin costo alguno. Para obtenerlos, llame al **1-866-918-4450** (TTY/TDD **711**).
Navajo	T'aa jiik'ehgo saad bee aka ana'alwo'igii, t'aa ajilii bee aka ana'alwo'igii, nitsahakees bee nidaalnishigii, saad bitsaa' dah naasha, doo t'aa ajilii bina'anish adiiljj' bee holo holne'go niha nił holo doo binahji' baa holo. Dii bee nil holoo dooleel, t'aa shoodi béeso bich'į' ya'at'éehigii **1-866-918-4450** (TTY/TDD **711**).
Chinese (Mandarin)	您可以免费使用语言协助服务、辅助设施与服务、较大的字型、口译服务，以及其他替代格式。如需获取，请致电 **1-866-918-4450** (TTY/TDD **711**)。
Chinese (Cantonese)	您可以免費使用語言協助服務、輔助設施與服務、較大的字型、口譯服務，以及其他替代格式。若要取得這些服務，請致電 **1-866-918-4450** (TTY/TDD **711**)。
Vietnamese	Dịch vụ hỗ trợ ngôn ngữ, dịch vụ hỗ trợ và trợ giúp phụ trợ, phông chữ lớn hơn, phiên dịch và các định dạng thay thế khác được cung cấp miễn phí cho quý vị. Để nhận dịch vụ này, vui lòng gọi số **1-866-918-4450** (TTY/TDD **711**).
Arabic	تتوفر لك خدمات مساعدة لغوية ومساعِدات وخدمات إضافية وخط أكبر وترجمة شفهية وغيرها من التنسيقات البديلة مجانًا. للحصول على ذلك، يُرجى الاتصال على الرقم **1-866-918-4450** (TTY/TDD **711**).
Tagalog	Ang mga serbisyo ng tulong sa wika, mga pansuportang tulong at serbisyo, malalaking font, pasalitang pagsasalin, at iba pang alternatibong format ay available para sa inyo nang wala kayong gagastusin. Para makuha ito, tumawag sa **1-866-918-4450** (TTY/TDD **711**).
Korean	언어 보조 서비스, 보조 지원과 서비스, 큰 글씨, 구두 번역 및 기타 대체 형식은 무료로 제공됩니다. 자세한 정보를 확인하려면 **1-866-918-4450**(TTY/TDD **711**) 번으로 전화해 주십시오.
French	Des services d'assistance linguistique, des aides et des services auxiliaires, une police plus grande, une traduction orale et d'autres formats sont disponibles gratuitement. Pour cela, veuillez appeler le **1-866-918-4450** (TTY/TDD **711**).
German	Ihnen stehen kostenlose Sprachassistenzdienste, Hilfsmittel und -dienste, größere Schrift, mündliche Übersetzungshilfen und andere alternative Formate zur Verfügung. Um dies zu erhalten, rufen Sie unter **1-866-918-4450** (TTY/TDD **711**) an.
Russian	Вы можете бесплатно получить услуги языковой поддержки, вспомогательные средства и услуги, включая услуги устного перевода, а также материалы крупным шрифтом и в других альтернативных форматах. Для получения данных услуг позвоните по номеру **1-866-918-4450** (TTY/TDD **711**).

AZCompleteHealth.com

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Japanese	言語支援サービス、補助支援およびサービス、大活字、通訳、その他の代替形式を無料でご利用いただけます。ご利用するには、**1-866-918-4450**（TTY/TDD **711**）までお電話ください。
Persian (Farsi)	خدمات کمک زبانی، وسایل و خدمات کمکی، ترجمه شفاهی و سایر فرمت‌های جایگزین به‌صورت رایگان در اختیار شما قرار دارد. برای دریافت این خدمات، لطفاً با شماره **1-866-918-4450** (TTY/TDD **711**) تماس بگیرید.
Syriac	ܬܫܡܫܝܬ̈ܐ ܕܡܥܕܪܢܘܬ̈ܐ ܠܫܢܝܬ̈ܐ، ܡܥܕܪܢܘܬ̈ܐ ܘܡܐܢ̈ܐ ܘܬܫܡܫܝܬ̈ܐ، ܦܘܢܛ ܪܒܐ ܠܟܬܒܬܐ، ܡܬܪܓܡܢܘܬܐ ܡܡܠܠܢܝܬܐ، ܘܐܦܪ̈ܡܛܐ ܐܚܪ̈ܢܐ ܟܠܗܝ ܐܝܬ ܡܓܢ. ܠܫܘܐܠܐ ܗܕܐ ܬܡܫܝܬ، ܡܩܪܐ ܠܗܕܢܐ ܡܢܝܢ ܠ **1-866-918-4450** (TTY/TDD **711**)
Serbo-Croatian	Dostupne su vam usluge jezičke pomoći, pomagala i pomoćne usluge, tekst veće veličine, usmeno prevođenje i drugi alternativni formati, i to besplatno. Da biste dobili ove usluge, pozovite broj **1-866-918-4450** (TTY/TDD **711**).
Thai	บริการช่วยเหลือด้านภาษา เครื่องมือช่วยเหลือและบริการเสริม แบบอักษรขนาดใหญ่ การแปลด้วยวาจา และรูปแบบอื่นๆ พร้อมให้คุณใช้งานโดยไม่มีค่าใช้จ่าย หากต้องการรับข้อมูลนี้ โปรดโทรติดต่อที่หมายเลข **1-866-918-4450** (TTY/TDD **711**)