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**)

CAD_150489E_ State Approved 04222024 AZ4CADFRM50489E_0524
©2024 Arizona Complete Health-Complete Care Plan.

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.)*

- -

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: ____________

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. Arizona Complete Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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
- Provides 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 and 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, you can file a grievance with the Chief Compliance Officer. 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.

Submit your grievance to:

Arizona Complete Health

Attn: Chief Compliance Officer

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

Fax: **1-866-388-2247**

Email: **AzCHGrievanceAndAppeals@AZCompleteHealth.com**

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 **http://www.hhs.gov/ocr/office/file/index.html**

CAD_96329M Internal Approved 07272022 - ESI AZ2CADINS08331M_0722
© 2022 Arizona Complete Health-Complete Care Plan. All rights reserved.

La Discriminación es un Delito

Arizona Complete Health cumple con las leyes de derechos civiles Federales vigentes y no discrimina por motivos de raza, color de piel, nacionalidad de origen, edad, discapacidad o sexo. Arizona Complete Health no excluye a personas ni las trata de forma diferente por motivos de raza, color de piel, nacionalidad de origen, edad, discapacidad o sexo.

Arizona Complete Health proporciona lo siguiente:

- Asistencia y servicios sin costo alguno a las personas con discapacidades para comunicarse de manera eficaz con nosotros, tales como intérpretes calificados de lengua de señas
- Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- Servicios de idiomas sin costo alguno a personas cuyo idioma principal no es el inglés, tales como intérpretes calificados e información escrita en otros idiomas

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

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

Si considera que Arizona Complete Health no le brindó estos servicios o lo discriminó de otra manera por motivos de raza, color de piel, nacionalidad de origen, edad, discapacidad o sexo, puede presentar una queja ante el Oficial de Cumplimiento. Puede presentar una queja en persona, por correo, fax o correo electrónico. Su queja se debe realizar por escrito y se debe enviar en un plazo de 180 días a partir de la fecha en que la persona que presenta la queja toma conocimiento de lo que se considera como discriminación.

Envíe su queja a la siguiente dirección:

Arizona Complete Health

Attn: Chief Compliance Officer

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

Fax: **1-866-388-2247**

Correo electrónico: **AzCHGrievanceAndAppeals@AZCompleteHealth.com**

También puede presentar una queja de derechos civiles a la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos a través del Portal de Quejas de la Oficina de Derechos Civiles, el cual se encuentra disponible en **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, o bien por correo a la siguiente dirección: U.S. Department of Health and Human Services; 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D. C. 20201. Asimismo, puede presentar dicha queja por teléfono llamando al **1-800-368-1019**, **1-800-537-7697** (TTY).

Los formularios de queja están disponibles en **http://www.hhs.gov/ocr/office/file/index.html**

CAD_96329M Internal Approved 07272022 - ESI AZ2CADINS08331M_0722
© 2022 Arizona Complete Health-Complete Care Plan. Todos los derechos reservados

arizona complete health

Attention: If you speak a language other than English, oral interpretation and written translation are available to you, at no cost, to understand the information provided. Call **1-866-918-4450** (TTY/TDD **711**).

Spanish	Si habla español, contamos con servicios de interpretación oral y traducción escrita, disponibles para usted de manera gratuita, para que pueda comprender la información. Llame al **1-866-918-4450** (TTY/TDD **711**).
Navajo	Dine k'ehji yanilti go ata' hane' ná hólo doo naaltsoos t'aa Dine k'ehji bee bik'e'ashchiigo nich'' adoolniilgo bee haz'a aldo ako dii t'a at'e t'aajiik'e kot'eegol nich'' sa'até. Koji holne **1-866-918-4450** (TTY/TDD **711**).
Chinese (Mandarin)	若您讲中文，我们会免费为您提供口译和笔译服务。请致电 **1-866-918-4450** (TTY/TDD **711**)。
Chinese (Cantonese)	我們為中文使用者免費提供口譯和筆譯。請致電 **1-866-918-4450** (TTY/TDD **711**)。
Vietnamese	Nếu quý vị nói tiếng Việt, quý vị được cung cấp dịch vụ phiên dịch và biên dịch, miễn phí, để quý vị hiểu được thông tin. Hãy gọi **1-866-918-4450** (TTY/TDD **711**).
Arabic	إذا كنت تتحدث لغة غير الإنكليزية، تتوفر لك ترجمة شفهية وترجمة كتابية مجانًا لكي تفهمَ المعلومات الموفَّرة. اتصل على الرقم **1-866-918-4450** (TTY/TDD **711**).
Tagalog	Kung ikaw ay nagsasalita ng Tagalog, may oral na interpretasyon at nakasulat na pagsasalin na maaari mong gamitin nang wala kang babayaran para maunawaan ang impormasyong ibinigay. Tumawag sa **1-866-918-4450** (TTY/TDD **711**).
Korean	한국어를 하실 경우, 제공된 정보의 이해를 위한 구두 통역 및 서면 번역 서비스를 무료로 제공해드릴 수 있습니다. **1-866-918-4450**(TTY/TDD **711**) 번으로 전화하십시오.
French	Si vous parlez français, vous disposez, sans frais, d'une interprétation orale et d'une traduction écrite pour pouvoir comprendre les informations fournies. Appelez le **1-866-918-4450** (TTY/TDD **711**).
German	Für alle, die Deutsch sprechen, stehen kostenlose Dolmetscher- und Übersetzungsservices zur Verfügung. Telefon: **1-866-918-4450** (TTY/TDD **711**).
Russian	Если вы говорите по-русски, вам бесплатно доступны услуги устного и письменного перевода предоставляемой информации. Звоните по телефону **1-866-918-4450** (TTY/TDD **711**).
Japanese	日本語を話される方は、　提供された情報を理解するための通訳（口頭）および翻訳（筆記）を無料でご利用いただけます。　電話番号 **1-866-918-4450**（TTY/TDD **711**）。
Persian (Farsi)	اگر به زبان انگلیسی صحبت نمیکنید، ترجمه شفاهی و کتبی به صورت رایگان برای شما در دسترس است تا بتوانید اطلاعات ارائه شده را متوجه شوید. با شماره **1-866-918-4450** (TTY/TDD **711**) تماس بگیرید.
Syriac	ܐܢ ܟܡܡܠܠܝܬܘܢ ܣܘܪܝܬ، ܡܨܐ ܗܘܐ ܠܟܘܢ ܡܬܬܠܐ ܡܢ ܡܘܗܒܐ ܕܬܘܪܓܡܐ ܕܦܘܡܐ ܘܕܟܬܝܒܬܐ ܡܓܢ. **1-866-918-4450** (TTY/TDD **711**).
Serbo-Croatian	Ako govorite srpski ili hrvatski, usmeno i pismeno prevođenje vam je dostupno besplatno. Nazovite **1-866-918-4450** (TTY/TDD **711**).
Thai	หากคุณพูดภาษา ไทย เรามีบริการล่ามและแปลเอกสาร โดยไม่มี โทรศัพท์ **1-866-918-4450** (TTY/TDD **711**).

AZCompleteHealth.com

CAD_96329M Internal Approved 07272022 AZ2CADINS08331M_0722

© 2022 Arizona Complete Health-Complete Care Plan. All rights reserved.