Consent for the Release of Confidential Information For Coordination of Care

Member's Name:	**Date of Birth:** ____ / ____ / ____
AHCCCS ID:	**CIS ID:**
Member Address:	

Under the Health Insurance Portability and Accountability Act (HIPAA), a health care provider or agency can use and share most of your health information to provide you with treatment, receive payment for your care, and manage and coordinate your care. However, your consent is needed to share certain types of health information. This form allows you to provide consent to share information regarding (1) behavioral and mental health services and referrals and (2) treatment for alcohol or substance use disorder. This information will only be shared to help diagnose, treat, manage, and get payment for your health needs. You can consent to share all of this information or just some information.

I. Who Can Disclose and Receive Your Information

I authorize all drug and alcohol programs, mental health agencies or providers, and medical care providers who have treated me to disclose to **Arizona Complete Health** and the following entities the health information specified in Section II below. I also authorize **Arizona Complete Health** and the following entities to communicate with and disclose to each other the health information specified in Section II below. The purpose of these disclosures is to help coordinate care and diagnose, treat, manage, and get payment for my health needs. (*Initial the entities that apply*):

____ All entities included in the **Arizona Complete Health Complete Care Plan.**

____ The following drug and alcohol programs, mental health agencies or providers, and medical care providers (*Fill in specific names below*):

1. Name(s) of Drug/Alcohol Program(s): _____
2. Name(s) of Mental Health Provider(s):_____
3. Name(s) of Medical Care Provider(s):_____
4. Name(s) of Supportive Housing Provider(s): _____
5. Other:_____

II. Information to be Disclosed (*Check all categories that apply*):

☐ All of my behavioral health and alcohol and drug treatment information.

☐ All of my behavioral health and alcohol and drug treatment information except: (*List types of health information you do not want shared*) _____

III. Acknowledgement

1. **Voluntary Consent**. Signing this consent is voluntary. I understand that I will not be denied services if I refuse to sign.
2. **Redisclosure**. The recipient of information related to alcohol and drug treatment is prohibited from redisclosing the information without my authorization, unless permitted to do so by this consent or under federal or state law. *See* 42 CFR Part 2. Records concerning mental health services I receive are protected by state law.
3. **Revocation**. I have the right to revoke this authorization, except to the extent that action has already been taken based on this authorization. I must send any revocation in writing to:
   Arizona Complete Health-Compliance, 1870 W. Rio Salado, 3A, Tempe, Arizona, 85281.
4. **Expiration Date**. This consent expires the earliest of the following: (1) the date I revoke consent; (2) the date I am no longer a Cenpatico member; or (3) the Event or Date specified below: _____
5. **Copy of Consent**. I am entitled to a copy of this consent form.

_____ __ / __ / ____

Signature (Member or Authorized Representative*). Date

**If signed by someone other than Member, please specify authority for signing and provide supporting documentation.*