Authorization to Use and Disclose Health Information

P.O. Box 25010
Little Rock, AR 72221

Notice to Member:

- Completing this form will allow Arkansas Total Care to (i) use your Protected Health Information (PHI) for a particular purpose, and/or (ii) share your health information with the individual or entity you identify on this form.
- You do not have to give permission to use or share your PHI. Your services and benefits with Arkansas Total Care will not change if you do not submit this form.
- If you want to cancel this form, send us a written request to revoke it at the address listed on this page. A revocation form can be sent to you by calling Member Services at the phone number on the back of your member ID card.
- Arkansas Total Care cannot promise that the person or group you allow us to share your PHI 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, call Member Services at the number on the back of your member ID card.
- Fill in all the fields on this form. When finished, mail the form and any supporting documentation to:

Arkansas Total Care
ATTN: Compliance Department
P.O. Box 25010
Little Rock, AR 72221

Aviso para el miembro:

- Al completar este formulario, autoriza a Arkansas Total Care (i) a utilizar su información de salud protegida (PHI) para un propósito en particular o (ii) a compartir su información de salud con la persona o entidad que indica en este formulario.
- No tiene la obligación de autorizar el uso o la divulgación de su PHI. Los servicios y beneficios que recibe de Arkansas Total Care no cambiarán si decide no enviar este formulario.
- Si desea cancelar este formulario, envíenos una solicitud por escrito para revocarlo a la dirección que se indica en esta página. Pueden enviarle un formulario de revocación si llama a Servicios al Miembro al número de teléfono que aparece al dorso de su tarjeta de identificación de miembro.
- Arkansas Total Care no puede garantizar que la persona o el grupo con quien nos permite compartir su PHI no la divulguen a otra persona.
- Guarde una copia de todos los formularios completos que nos envía. Podemos enviarle copias si las necesita.
- Si precisa ayuda, comuníquese con Servicios al Miembro al número que aparece al dorso de su tarjeta de identificación de miembro.
- Complete todos los campos de este formulario. Cuando termine, envíe el formulario y cualquier documentación de respaldo por correo a la siguiente dirección:

Arkansas Total Care
ATTN: Compliance Department
P.O. Box 25010
Little Rock, AR 72221

Member ID Number: U_____

Member ID Number: U _____

PLEASE READ THE INSTRUCTIONS CAREFULLY AND COMPLETE THE FORM BELOW. INCOMPLETE FORMS WILL NOT BE ACCEPTED.

CARE COORDINATOR NAME: _____

1 **MEMBER INFORMATION:**

Name *(print):* _____ Date of Birth:_____

Address: _____

City: _____ State: _____ ZIP:_____ Phone: (___) _____-_____

2 **I GIVE ARKANSAS TOTAL CARE PERMISSION TO USE MY PHI FOR THE PURPOSE IDENTIFIED OR TO SHARE MY PHI WITH THE PERSON OR GROUP NAMED BELOW. THE PURPOSE OF THE AUTHORIZATION IS** *(check one option below)**:***

□ to allow Arkansas Total Care to help me with my benefits and services, **OR**

□ to allow Arkansas Total Care to use or share my PHI 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 PERMIT ARKANSAS TOTAL CARE TO USE OR SHARE THE FOLLOWING PHI** *(NOTE: Select the first statement to release <u>all</u> PHI or select the second statement to release only <u>some</u> PHI. **Do NOT select both.**)*

□ **All of my PHI, 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 PHI EXCEPT** *(check only the boxes below that apply)**:***

- □ Genetic information, services, or tests.
- □ HIV/AIDS data and records.
- □ Drug and alcohol data and records.
- □ Mental health data and records (but not psychotherapy notes).
- □ Prescription drug/medication data and records.
- □ Other:_____

5 **THIS AUTHORIZATION ENDS ON THIS DATE/EVENT:_____**

Enter the date your permission will end unless canceled. You must fill out this field.

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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 THIS FORM AND ANY SUPPORTING MATERIALS TO
Arkansas Total Care, ATTN: COMPLIANCE DEPARTMENT
P.O. Box 25010 Little Rock, AR 72221

Member ID Number: U ___________________

ADDITIONAL PERSON(S) OR GROUP(S) TO RECEIVE PROTECTED HEALTH INFORMATION:

NOTE: If you would like, you can share any substance use disorder (SUD) records with someone other than a third-party payor or a healthcare provider, facility, or program where you get services from a treating provider. This can include a health insurance exchange or a research institution (hereafter, “Recipient Entity”). If you agree to share your SUD records with a Recipient Entity, you must specify the name of the person or entity you get services from at the Recipient Entity. Or, you can state that your SUD records may be shared with your current and future treating providers at the 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: ___________________

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Address: ___________________

City: ___________ State: ___________ ZIP: ___________ Phone: ( ) -

Name (individual or entity): ___________________

Address: ___________________

City: ___________ State: ___________ ZIP: ___________ Phone: ( ) -

Name (individual or entity): ___________________

Address: ___________________

City: ___________ State: ___________ ZIP: ___________ Phone: ( ) -