Authorization to Use and Disclose Health Information

Notice to Member:

- Completing this form will allow Arkansas Total Care to use your health information for a particular purpose, and/or share your health information with the individual or entity that you identify on this form.
- If you supply a general designation to disclose information, you may request a list of entities to which your information has been disclosed.
- You do not have to sign this form or give permission to use or share your health information. Your services and benefits with Arkansas Total Care will not change if you do not sign this form.
- Right to cancel (revoke): This authorization/consent form is subject to revocation at any time except to the extent that the Arkansas Total Care for other lawful holder of your health information that is permitted to share it has already acted in reliance on it. If you want to cancel this Authorization Form, fill out the Revocation Form on the last page and mail it to the address at the bottom of the page.
- Arkansas Total Care cannot promise that the person or group you allow us to share your health information with will not share it with someone else. 42 CFR Part 2 prohibits the recipient of alcohol and drug treatment information from unauthorized re-disclosure.
- Keep a copy of all completed forms that you send to us. We can send you copies if you need them.
- Fill in all the information on this form. When finished, mail it to the address at the bottom of the first page.

MEMBER INFORMATION:

Member Name (print): _____

Member Date of Birth: _____ *Medicaid* ID: _____

Member Address: _____

Member Phone: (_____) _____ - _____

I authorize all drug and alcohol programs, mental health agencies or providers, and medical care providers (past/current/future) who treat me to disclose to Arkansas Total Care the health information specified below. I also authorize Arkansas Total Care and the following entities to communicate with and disclose to each other the health information specified below. The purpose of these disclosures is to help coordinate care and diagnose, treat, manage, and get payment for my health needs.

PERSON OR GROUP TO RECEIVE INFORMATION (add additional Persons or Groups on page 2):

Name (person or group): _____

Address: _____

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

I AUTHORIZE Arkansas Total Care TO USE OR SHARE THE FOLLOWING HEALTH INFORMATION:

☐ **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 all boxes that apply):**

- ☐ Genetic information, services or tests
- ☐ AIDS or HIV 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: _____

Expiration Date: **This consent expires the earliest of the following: (1) the date I revoke consent; (2) the date I am no longer a Arkansas Total Care member; or (3) the event or date specified:** _____

Member Signature: _____ **Date:** _____ /_____ /_____

(Member or Legal Representative Sign Here)

If you are signing for the Member, describe your relationship below. If you are the Member's personal representative, describe this below and send us copies of those forms (such as power of attorney or order of guardianship).

Mail to: Arkansas Total Care Attn: Privacy Officer, P.O. Box 25010, Little Rock, AR 72221

Phone: 1-866-282-6280 (TDD/TTY: 711)

ADDITIONAL INDIVIDUAL PERSON(S) OR ENTITY(IES) TO RECEIVE INFORMATION

NOTE: If you are consenting to disclose any substance use disorder records to an 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: (_____) _____ - _________

Revocation of Authorization to Use and/or Disclose Health Information

I want to cancel, or revoke, the permission I gave to Arkansas Total Care to use my health information for a particular purpose or to share my health information with a person or group:

PERSON OR GROUP THAT RECEIVED THE INFORMATION:

Name (person or group): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____ - _____

Authorization Signed Date (if known): _____ /_____ /_____

MEMBER INFORMATION:

Member Name (print): _____

Member Date of Birth: _____ /_____ /_____ Medicaid ID _____

Member Address: _____

Member City: _____ Member State: _____ Member Zip: _____

Member Phone: (_____) _____ - _____

I understand that my health information (including, where applicable, my substance use disorder records) may have already been used or shared because of the permission I gave before. I also understand that this cancellation only applies to the permission I gave to use my health information for a particular purpose or to share my health information with the person or group. It does not cancel any other authorization forms I signed for health information to be used for another purpose or shared with another person or group.

Member Signature: _____ **Date:** _____ /_____ /_____

(Member or Legal Representative Sign Here)

If you are signing for the Member, describe your relationship below. If you are the Member's personal representative, describe this below and send us copies of those forms (such as power of attorney or order of guardianship).

Arkansas Total Care will stop using or sharing your health information when we receive and process this form. Use the mailing address below. You can also call for help at the number below.

Arkansas Total Care
Attn: Privacy Officer
P.O. Box *25010*
Little Rock, AR 72221
Phone: *1-866-282-6280 (TDD/TTY: 711)*

Statement of Non-Discrimination

Arkansas Total Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Arkansas Total Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex

Arkansas Total Care:

Provides free aids and services 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 free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Arkansas Total Care at 1-866-282-6280 or TDD/TTY: 711. If you believe that Arkansas Total Care has 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: Arkansas Total Care Quality Department, Arkansas Total Care, P.O. Box 25010, Little Rock, Arkansas 72221, 1-866-282-6280 or TDD/TTY: 711. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance Arkansas Total Care 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 or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

All materials are available for written or oral translation, in your language or alternative formats at no cost by calling 1-866-282-6280 or TDD/TTY: 711.

Language Assistance:

Spanish:
Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Arkansas Total Care tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-866-282-6280 or TDD/TTY: 711.

Vietnamese:
Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Arkansas Total Care, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-866-282-6280 or TDD/TTY: 711.

Marshallese:
Ñe kwe, ak bar juon eo kwōj jipañe, ewōr an kajjitōk kōn Arkansas Total Care, ewōr aṃ jimwe in bōk jipañ im melele ko ilo kajin eo aṃ ejjeḷọk wōṇāān. Ñan kōnono ippān juon ri-ukōk, kirlọk 1-866-282-6280 TDD/TTY: 711.

Chinese:
如果您，或是您正在協助的對象，有關於 Arkansas Total Care 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-866-282-6280 or TDD/TTY: 711.

Laotian:
ຖ້າທ່ານ ຫ ູ ືຄົນທ ່ທ່ານກໍາລັງຊ່ວຍເຫ ູ ືອ ມ ຄໍາຖາມກ່ຽວກັບ Arkansas Total Care, ທ່ານມ ສິດທ ່ຈະໄດ້ຮັບການຊ່ວຍເຫ ູ ືອແລະຂໍ້ມູນຂ່າວສານທ ່ເປັນພາສາຂອງທ່ານ ໂດຍບ່ມ ຄ່າໃຊ້ຈ່າຍ. ເຜ ື່ອຈະເວ ົ້າກັບນາຍພາສາ ໃຫ ໂທຫາ 1-866-282-6280 or TDD/TTY: 711.

Tagalog:
Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Arkansas Total Care, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-866-282-6280 or TDD/TTY: 711.

Arabic:
إذا كان لديك أو لدى شخص تساعده أسئلة حول Arkansas Total Care ، المساعدة على الحصول في الحق لديك تكلفة أية دون من بلغتك الضرورية والمعلومات. للتحدث مع مترجم اتصل ب 1-866-282-6280 or TDD/TTY: 711.

German:
Falls Sie oder jemand, dem Sie helfen, Fragen zu Arkansas Total Care hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-866-282-6280 or TDD/TTY: 711.

French:
Si vous-même ou une personne que vous aidez avez des questions à propos Arkansas Total Care, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-866-282-6280 or TDD/TTY: 711.

Hmong:
Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Arkansas Total Care, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-866-282-6280 or TDD/TTY: 711.

Korean:
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Arkansas Total Care 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-866-282-6280 or TDD/TTY: 711 로 전화하십시오.

Portuguese:
Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Arkansas Total Care, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-866-282-6280 or TDD/TTY: 711.

Japanese:
Arkansas Total Care について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-866-282-6280 or TDD/TTY: 711 までお電話ください。

Hindi:
आप या जिसकी आप मदद कर रहे हैं उनके, Arkansas Total Care के बारे में कोई सवाल हों, तो आपको बबना ककसी खर्च के अपनी भाषा में मदद और ि◌ानकारी प्राप्त करने का अधिकार है। ककसी दुभाषषये से बात करने के ललए 1-866-282-6280 or TDD/TTY: 711 पर कॉल करें।

Gujarati:
જે તમને અથવા તમે જેમની મદદ કરી રહ્યા હોય તેમને Arkansas Total Care વવશે કોઈ પ્રશ્ન હોય તો તમને, કોઈ ખર્ચ વવના તમારી ભાષામાાં મદદ અને માહહતી પ્રાપ્ત કરવાનો અવિકાર છે. દુભાવષયા સાથે વાત કરવા માટે 1-866-282-6280 or TDD/TTY: 711