



Privacy Authorization Form

Date: _____

Member Name: _____ Member Date of Birth: _____ Mercy Care ID #: _____

Address: _____ Phone: () _____
Street City, State Zip

Are you the member? Yes No If NO, tell Mercy Care Plan/Mercy Care Advantage who you are by checking one of the boxes below. Please give Mercy Care Plan/Mercy Care Advantage copies of any papers that show you have the right to make this request.

- I am the member's Dad/Mom or guardian.
I make health care decisions for the member.
The member has died, and I take care of his or her assets.
Other (explain)

Name of Requestor (if not member): _____ Date of Request: _____

Requestor Address (if not member): _____
Street City, State Zip Telephone Number

I want Mercy Care Plan/Mercy Care Advantage to use or give out records of the member named above because:

- I (the member or person acting for the member) want Mercy Care Plan/Mercy Care Advantage to give out the information described below.
To help Mercy Care Plan/Mercy Care Advantage coordinate the member's health care
For workers' compensation claims
For insurance coverage or payment for care
Other (tell us):

- You may / may not (check box that applies) give out any records about:
AIDS/HIV and other communicable disease (e.g. venereal disease)
Mental health information (including behavioral health and psychiatric care)
Alcohol and/or drug abuse treatment
Genetic testing information

I authorize Mercy Care Plan/Mercy Care Advantage to use or give out records of the member named above to

Enter name of person/entity: _____

Enter address, phone and fax number if known: _____

Tell Mercy Care Plan/Mercy Care Advantage what you want us to give out. You need to provide dates of service, names of providers, etc.

Three horizontal lines for providing details of requested records.

I (the member or person acting for the member) agree to the following:

- I may authorize Mercy Care Plan/Mercy Care Advantage to use or give out member records. When I give an approval, Mercy Care Plan/Mercy Care Advantage will give out member records to a person or company.
- I know that member records can't always be kept safe under privacy laws. I know a person or company that receives member records can give them out again.
- I may take back this authorization by submitting to Mercy Care Plan/Mercy Care Advantage a request in writing.
- I may not be allowed to take back an authorization in some cases. I can learn more about this in the Mercy Care Plan/Mercy Care Advantage's Notice of Privacy Practices.
- This authorization will end in twelve (12) months from the date of signature.
- If I want this authorization to end before this date, I will tell Mercy Care Plan/Mercy Care Advantage when and the reason I want it to end. Use the space below to explain:

- I have read and understand this form.
- I am entitled to receive a copy of this form.

If member - Signature of Member

Date

If member -Print Member Name

If not member - Signature of Legal Representative

Date

Print Name of Legal Representative

Please send this Privacy Authorization Form to:
Mercy Care Plan/Mercy Care Advantage
4350 E. Cotton Center Blvd., Bldg. D
Phoenix, AZ 85040

Call Mercy Care Plan/Mercy Care Advantage at 800-624-3879 with questions or comments.

Referral from (specify name of Mercy Care Plan/Mercy Care Advantage employee who sent auth form to requester):

Effective Date: 4/03
Revised Date: 02/04