



Authorization to Use or Disclose Protected Health Information (PHI)

Federal rules providing certain protections of the privacy of individuals' health information may require your authorization before the Plan may use, receive or disclose protected health information.

Complete the following chart with information about the person whose PHI is subject to this request.

Name	Date of Birth	Phone #:
Address		

If you are not the employee, complete the following:

Employee name	Employee ID#	Employee date of birth
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I hereby authorize the use or disclosure of my PHI as described in this Authorization. I understand that this Authorization is voluntary and that I may revoke it at any time by giving a written statement that I am revoking this Authorization to the Privacy Official at the address at the end of this Authorization.

1. Specific description of the PHI that I am authorizing to be used or disclosed (include dates to which the information pertains, if applicable) _____

2. Name, or other specific identification, of the person(s) or organization(s) I am authorizing to make the requested use or disclosure of the PHI described above _____

3. Name, or other specific identification, of the person(s), or organization(s) I am authorizing to receive the PHI described above _____

4. State the specific purpose for which you are authorizing the use or disclosure of the PHI described above:

Check this box to indicate the following: "This request is at my own request", or:

Describe the specific reason for the request _____

5. This authorization is in effect from _____ to _____ (the time period). **An authorization cannot be valid for a time period of more than 12 months.** Upon the conclusion of the time period, this authorization is automatically revoked and invalid.

Important Information About This Authorization and Your Rights

- You may refuse to sign this Authorization. The Plan will not condition eligibility for, enrollment in, or payment of benefits under the Plan on provision of this Authorization.
- You may revoke this Authorization at any time by giving your written, signed statement that you are revoking this Authorization to the Privacy Official at the address at the end of this Authorization. A form to revoke your Authorization is available from the Privacy Official. Your revocation will be effective when received, but any use or disclosure occurring before receipt of your revocation will not be affected by it. In addition, if action has been taken in reliance on the Authorization, you will not be able to revoke the Authorization with respect to subsequent uses and disclosures in connection with that action
- You may inspect or copy the PHI described in Item 1 by requesting to do so.
- If PHI is disclosed pursuant to this Authorization, it may no longer be protected under the terms of the federal rules providing certain protections of the privacy of individuals' health information, and that health information may be re-disclosed by the recipient. You may wish to obtain assurances from the person(s) or organization(s) specified in Item 3 above that they will not further disclose your PHI that they receive pursuant to this Authorization.
- If the Plan requested this authorization, the Plan's request should not be taken as an indication that the Plan has concluded that the use or disclosure for which the Plan is requesting your authorization would be prohibited if you do not give the requested authorization.
- If the Plan is requesting this Authorization, you will be provided with a signed copy of it.

By signing below, I certify that I have read and understand this Authorization. If I am a personal representative I certify and attest that I am the duly authorized representative of the person whose PHI is to be used or disclosed pursuant to this Authorization. *(A personal representative may be requested to provide verification of representative status.)*

Signature of applicant or personal representative

Date

Relationship of personal representative to member: _____

Send completed form to:

**Privacy Official
Human Resources
7575 E. Main Street
Scottsdale, AZ 85251
Phone: (480) 312-7600 FAX: (480) 312-7960**