ARIZONA BEHAVIORAL HEALTH CORPORATION

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosures and/or use of individually identifiable health information, as set forth below, consistent with Arizona and Federal law concerning the privacy of such information. Failure to provide all information requested will invalidate this Authorization.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use and disclosure of my Protected Health Information (PHI) as follows:

Enrolled Member Name: _____

Persons/Organizations authorized to use or disclose the information:

- **Arizona Behavioral Health Corporation (ABC)**
- **Arizona Health Care Cost Containment System (AHCCCS)**
- **HOM, Inc. (HOM)**
- **The Managed Care Organization with whom the member is enrolled.**
- **Data Warehouse for Enterprise Linkage Arizona (DWEL-AZ)**
- **Government Public Housing Authorities or other Affordable Housing Provider**
- **The service team, case manager, care coordinator or other designated housing supportive service provider the member may be working with.**

Purpose of the use or disclosure:

Information will be used to facilitate, manage and comply with State and Federal requirements related to the Federal and/or State housing subsidy of the individual named above and to assist the member in attaining and maintaining housing placement and subsidy support. Further details and examples are provided in the ABC Privacy Notice.

This Authorization applies to the following information

Name, AHCCCS enrollment and enrollment in RBHA or any successor corporation that contracts with the State of Arizona to provide behavioral health services in Arizona, verification of Serious Mental Illness diagnosis and information required to verify eligibility and prioritization for the housing program.

EXPIRATION

This authorization will expire one year from the date this document is signed below.

RESTRICTIONS

This Authorization may not be used to release Substance Abuse or Confidential Communicable Disease/1-IIV information in combination with any other health care information. Federal law requires a specific Authorization be used for the disclosure of this information.

If we share your PHI with the people or agencies that you name, they may share it with others if allowed under the law.

YOUR RIGHTS

I understand that I may refuse to sign this Authorization, and:

- My refusal will not affect my eligibility for AHCCCS benefits,
- My health care and the payment for my health care will not be affected, and
- If I do not sign this form, it may prevent me from participation in any housing program administered by ABC.

I may inspect or copy any information used or disclosed under this Authorization, unless the information is contraindicated as determined by my psychiatrist. I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf by an authorized representative and sent abchousing@azabc.org to be processed by an ABC Housing Program Specialist. My revocation will be effective upon receipt but will not be effective to the extent that the Requesting Party or others have acted in reliance upon this Authorization. I have a right to receive a copy of this Authorization and a copy of the ABC Privacy Notice.

MEMBER SIGNATURE

Signature: _____ _____

Enrolled Member/Representative/Guardian Date:

If signed by someone other than the Enrolled Member, state your relationship to the Member:

_____

REFERRING AGENCY SIGNATURE

Name: _____

Title: _____

Date: _____

Note: This form may not be used to release psychotherapy notes in combination with other types of health information (45 CFR § 164.508(b)(ii). If this form is being used to authorize the release of psychotherapy notes, a separate form must be used to authorize release of any other Protected Health Information.