



# Protected Health Information (PHI) Access Request

**Protected Health Information (PHI) means information about your health. This form must be completed and signed to process this request.**

## 1. Who is the Medicaid Member?

First name	Last name	Middle initial
Member ID number	Birth date (MM/DD/YYYY)	Phone number
Street		
City, state, ZIP code		

## 2. Description of a PHI Report

Once we get this signed request form, we will provide you with a PHI Report. The report will have the last 24 months of PHI data that we have. If you want PHI for different dates, fill in the dates below.

From: \_\_\_\_\_ To: \_\_\_\_\_

If you have Long Term Care (LTC) benefits and want that information, check the correct box below.

I want the report to include LTC information       I only want LTC information in the report.

## 3. Where do you want this PHI Report to be sent?

Who is receiving this PHI Report?

Member       Member's Legal Representative       Member's Natural or Adoptive Parent

Print name of recipient

Recipient's street

City, state, ZIP code

**Important Information:**

- By signing this form, I allow Mercy Care to give PHI about the Member named in **Section 1** to the recipient named in **Section 3**.
- This approval is only for this request.
- This report may include information about chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, sexually-transmitted diseases, HIV/AIDS, and/or genetic marker.
- This PHI Report does not include psychotherapy notes.
- Information in this report could be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws.

**4. Signature of Member or Authorized Representative**

Signature	Date
Print name	
If a legal representative signed this form, describe the relationship: (parent, legal guardian, Power of Attorney, personal representative)	

**Authorized Representative** means you have legal proof that you can act for this person. A representative signs for a person who cannot legally sign on his or her own. If the member is less than 18 years old, a parent, or guardian should sign for the minor. If you are a representative signing this form you must send legal proof you can act for this person.

Do you have questions? We can help. Call Mercy Care at: 800-624-3879.

**Please sign and return this completed form to: Mercy Care  
4755 S. 44<sup>th</sup> Place  
Phoenix, AZ 85040**

Please allow 30 days for our response.

## Nondiscrimination Notice

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

### Mercy Care:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - o Qualified sign language interpreters
  - o 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:
  - o Qualified interpreters
  - o Information written in other languages

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card or **1-800-385-4104 (TTY: 711)**.

If you believe that Mercy 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 our Civil Rights Coordinator at:

Address: Attn: Civil Rights Coordinator  
4500 East Cotton Center Boulevard  
Phoenix, AZ 85040  
Telephone: **1-888-234-7358 (TTY 711)**  
Email: [MedicaidCRCoordinator@mercycaresaz.org](mailto:MedicaidCRCoordinator@mercycaresaz.org)

You can file a grievance in person or by mail or email. If you need help filing a grievance, our Civil Rights Coordinator 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, SW 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>.

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## Multi-language Interpreter Services

**ENGLISH: ATTENTION:** If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card or **1-800-385-4104 (TTY: 711)**.

**SPANISH: ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que aparece en el reverso de su tarjeta de identificación o al **1-800-385-4104 (TTY: 711)**.

**NAVAJO: Díí BAA AKÓNÍNÍZIN:** Díí bee yáníítí'go, saad bee áká'ánída'awo'déé', t'áá jik'eh, éí ná hóló. Níinaaltsoos níít'ízi bee nééhozinígíí bine'déé' béésh bee hane'í biká'ígíí bee hodílnih doodago **1-800-385-4104 (TTY: 711)** hólne' dooleet.

**CHINESE: 注意:** 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電您的 ID 卡背面的電話號碼或 **1-800-385-4104 (TTY: 711)**。

**VIETNAMESE: CHÚ Ý:** nếu bạn nói tiếng việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi số có ở mặt sau thẻ id của bạn hoặc **1-800-385-4104 (TTY: 711)**.

**ARABIC:** ملحوظة: إذا كنت تتحدث باللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل على الرقم الموجود خلف بطاقتك الشخصية أو على **1-800-385-4104 (للصم والبكم: 711)**.

**TAGALOG: PAUNAWA:** Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tumawag sa numero na nasa likod ng iyong ID card o sa **1-800-385-4104 (TTY: 711)**.

**KOREAN: 주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드 뒷면에 있는 번호로나 **1-800-385-4104 (TTY: 711)** 번으로 연락해 주십시오.

**FRENCH: ATTENTION:** si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro indiqué au verso de votre carte d'identité ou le **1-800-385-4104 (ATS: 711)**.

**GERMAN: ACHTUNG:** Wenn Sie deutschen sprechen, können Sie unseren kostenlosen Sprachservice nutzen. Rufen Sie die Nummer auf der Rückseite Ihrer ID-Karte oder **1-800-385-4104 (TTY: 711)** an.

**RUSSIAN: ВНИМАНИЕ:** если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки, или по номеру **1-800-385-4104 (TTY: 711)**.

**JAPANESE: 注意事項:**日本語をお話になる方は、無料で言語サポートのサービスをご利用いただけます。IDカード裏面の電話番号、または**1-800-385-4104 (TTY: 711)**までご連絡ください。

**PERSIAN:** اگر به زبان فارسی صحبت می کنید، به صورت رایگان می توانید به خدمات کمک زبانی دسترسی داشته باشید. با شماره درج شده در پشت کارت شناسایی یا با شماره **1-800-385-4104 (TTY: 711)** تماس بگیرید.

**SYRIAC:** ملحوظة: إذا كنت تتحدث باللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل على الرقم الموجود خلف بطاقتك الشخصية أو على **1-800-385-4104 (للصم والبكم: 711)**.

**SERBO-CROATIAN: OBAVEŠTENJE:** Ako govorite srpski, usluge jezičke pomoći dostupne su vam besplatno. Pozovite broj na poledini vaše identifikacione kartice ili broj **1-800-385-4104 (TTY – telefon za osobe sa oštećenim govorom ili sluhom: 711)**.

**SOMALI: FEEJIGNAAN:** Haddii af-Soomaali aad ku hadasho, adeegyada gargaarka luqadda, oo bilaash ah, ayaad heli kartaa. Wac lambarka ku qoran dhabarka dambe ee kaarkaaga aqoonsiga ama **1-800-385-4104 (Kuwa Maqalka ku Adag 711)**.

**THAI: ข้อควรระวัง:** หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทรติดต่อหมายเลขที่อยู่ด้านหลังบัตร ID ของคุณ หรือหมายเลข **1-800-385-4104 (TTY: 711)**  
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