mercy care | mercy care advantage HMO SNP

**Privacy Request Form**

Date of Request: _____

**To request member information from Mercy Care, please check one or more of the boxes below.**

- ☐ Receive copy of privacy practices.
- ☐ Receive claim records.
- ☐ Change something in member records.
- ☐ Receive list of organizations to whom Mercy Care gives out member records.
- ☐ Limit how Mercy Care uses and gives out member records.

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

Phone: (_____) _____

**Are you the member?** ☐ Yes ☐ No **If "NO", tell Mercy Care who you are by checking one of the boxes below. Please give Mercy Care copies of 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 estate.
- ☐ Other (explain)_____

Name of Requestor (if not member): _____

**Please Explain Your Request**

Please tell us what you want to receive and why. You need to provide dates of service, names of providers, etc. Mercy Care may charge you to receive copies of member records or a list of people and companies to which we give out member records. You need to tell Mercy Care if you can not pay any fee.

_____

_____

_____

**Where Do You Want The Records Sent**

Address: _____

Street City, State Zip

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

- I may authorize [Plan] to use or give out member records. When I give an approval, [Plan] 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 [Plan] 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 [Plan]'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 the Plan 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

Please send this Privacy Request Form to:

**Mercy Care/Mercy Care Advantage**
**Privacy Officer or Coordinator**
**4500 E. Cotton Center Blvd.**
**Phoenix, AZ 85040**

Call Mercy Care/Mercy Care Advantage at 1-800-624-3879 with questions or comments.

Revised: 10/09