PUBLIC SAFETY/CORP CANCER INSURANCE POLICY PROGRAM

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

AFN: HIP-004 (03/2023)

I hereby authorize Public Safety/Corp Cancer Insurance Policy Program to use and/or disclose my protected health information as described below:

Persons to Whom Disclosures May Be Made of the Information Identified Herein:

Purpose of Disclosure:

Type of Information to Be Disclosed:

☐ Entire Medical Record ☐ Claim Information ☐ Other:

☐ Billing Statements

☐ Enrollment Information

Expiration: Insert Date ***(MM/DD/YYYY)***

This authorization will expire 180 days from the date of signing **OR** (*insert date* ➔):

I understand that:

1. **MY REFUSAL TO SIGN THIS DOCUMENT OR SUBSEQUENT REVOCATION OF THIS SIGNED AUTHORIZATION MAY NOT BE USED AS THE BASIS FOR DENYING MY TREATMENT, PAYMENT, AND ENROLLMENT, OR ELIGIBILITY FOR BENEFITS.**
2. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3. I may revoke this authorization at any time by notifying Public Safety/Corp Cancer Insurance Policy Program in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4. Information disclosed under this authorization is subject to re-disclosure by the recipient; however, any information disclosed to health care providers, insurance companies, insurance agents and brokers, health plans and health plan administrators, will continue to be protected and not be reused or re-disclosed other than as authorized by me or permitted by law.

I have read and understood the information above and with my signature below, authorize the receipt, use and disclosure of the information described in this document for the limited purposes identified herein. No promises or representations have been made to me to induce me to sign this form.

Participant Name:	**Participant ID #:**
Participant: Your 'Typed' First and Last Name Constitutes Your Signature	**Date *(MM/DD/YYYY)***

COMPLETE ALL SECTIONS OF THE FORM AND RETURN TO:

Cancer Insurance Department
PO Box 17323
Phoenix, AZ 85011-0323

Email: ***cancerinsurance@psprs.com***
Phone: **(602)-255-5575**
Fax: **(602)-296-2371**

STATE OF ARIZONA)

COUNTY OF _____)

NOTARY ACKNOWLEDGMENT

On this _____day of _____, 20_____, before me personally
[Day] [Month] [Year]

appeared_____, whose identity was proven
[Name of signer]

to me on the basis of satisfactory evidence to be the person who he or she claims to be, and acknowledged that he or she signed the above / attached document.

_____

(Seal) [Affix Seal Here] **Notary Public [Notary Public Signature]**

**** For Office Use Only ****

ID Verification Completed By:

Date Verification Completed:

(MM DD YYYY format)

Notes: