Mercy Healthcare Group

Privacy Request Form

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

- ☐ Receive copy of privacy practices.
- ☐ Receive member records.
- ☐ Change something in member records.
- ☐ Receive list of organizations to whom Mercy Healthcare Group gives out member records.
- ☐ Limit how Mercy Healthcare Group uses and gives out member records.
- ☐ Receive member records in a safe and private way.
- ☐ Make a privacy complaint.

Member Name: _____ Member Date of Birth: _____ Mercy Healthcare Group ID #: _____

Address: _____ Phone: (___) _____
Street City, State Zip

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

Name of Requestor (if not member): _____ Date of Request: _____

Requestor Address: _____
Street City, State Zip

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 Healthcare Group 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 Healthcare Group if you cannot pay any fee.

_____

_____

Will giving out member records put you or anyone else in danger? **Check one**: ☐ Yes ☐ No

How Mercy Healthcare Group Will Get Member Records to You

Please tell us how you want to receive the information you asked for (check box):

- ☐ I want Mercy Healthcare Group to mail the information to me at my address above.
- ☐ I want Mercy Healthcare Group to mail the information to me at a different address. Please list address (if different from the one above).

_____

- ☐ Other _____

I assure you that I am the person stated above. I have the legal right to receive records on the member named above.

_____ _____
Requestors Signature **Date**

Please send this Privacy Request Form to:

Mercy Healthcare Group Privacy Officer or Coordinator
4350 E. Cotton Center Blvd., Bldg. D
Phoenix, AZ 85040
Call Mercy Healthcare Group at 800-780-2300 with questions or comments.

Effective Date: 4/03