Protected Health Information (PHI) Access Request

ECHS Category - PHIA

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	Birthdate *(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 Aetna 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 Aetna at: 1-866-600-2139.**

Please sign and return this completed form to: **Aetna HIPAA Member Rights Team**
PO Box 14079
Lexington, KY 40512-4079

Or you can fax it to: **859-280-1272**

Please allow 30 days for our response.