Authorization to Release Protected Health Information (PHI)

ECHS Category - PHIA

Protected Health Information (PHI) means information about your health. Federal and state laws protect the privacy of your PHI. By signing this paper, you give us your **OK**. We will only give out the PHI that you say we can share. And, we will only give it to the people or agencies that you list.

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. Who can the PHI be given to?

Person or company name	Phone number
Street	
City, state and ZIP code	
Person or company name	Phone number
Street	
City, state and ZIP code	

NOTICE TO ANYONE OTHER THAN THE MEMBER:
Information disclosed to you pertaining to certain conditions, such as treatment for alcohol or drug abuse, HIV/AIDS and other sexually transmitted diseases, behavioral health, and genetic marker information is protected by various federal and state laws which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by such laws. Any unauthorized further disclosure in violation of state or federal law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient consent for release of these types of information. The federal rule at 42 CFR Part 2 restricts use of the information disclosed to criminally investigate or prosecute any alcohol or drug abuse patient.

"Aetna" also includes Aetna's subsidiaries, affiliates, employees, agents and subcontractors.

3. What PHI can we share?

We will **only** share the PHI that you **OK**. Tell us the type of PHI by checking the box.

- ☐ Any information requested
- ☐ Health (medical, dental, pharmacy, vision)
- ☐ Mental health, but NOT psychotherapy notes
- ☐ Substance use disorder diagnosis and treatment, but NOT psychotherapy/ counseling notes related to substance use disorder diagnosis and treatment
- ☐ Long term care
- ☐ Patient management records
- ☐ Other (please explain): _____

4. Why are you giving out this PHI?

Reason/Purpose:

5. This form is good for 1 year unless you give a shorter time below.

My OK is good from:

_____ to _____

MM/DD/YYYY MM/DD/YYYY

By signing below, I understand and agree:

- I can take back my **OK** by writing to the address on this form.
- If you take back your **OK** it won't take back the PHI we already shared. But we will not share any more of your PHI.
- My chance to sign up for insurance will not change if I don't sign this form.
- Whoever gets my PHI may share it with others. That means laws may not be able to protect my PHI.
- The PHI I **OK** to share may include:
  - Health condition and treatment information.
  - Chronic diseases
  - Mental health conditions
  - Substance use disorder diagnosis or treatment .
  - Transmissible diseases, sexually transmitted diseases (HIV/AIDS), and genetic marker information.
- I can get a copy of this **OK** by writing to the address on this form.
- Aetna will not share my PHI with whom I named unless I sign this form, and not with anyone else.

ATTENTION:

I must sign this form if any of the options below apply.

- I am 18 years of age or older.
- I am under 18 years of age and I am married or emancipated.
- My state allows me to be treated even if my parents or legal guardian do not agree.
- My PHI being shared may include one or more of the below conditions:
  - Substance use disorder diagnosis or treatment
  - Mental health conditions
  - Sexually transmitted disease (including HIV/AIDS)
  - Reproductive health (including contraception, prenatal care and abortion)

6. 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)	

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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**

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex and does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. If you speak a language other than English, free language assistance services are available. Visit our website at or call the phone number listed in this material.

In addition, your health plan provides auxiliary aids and services, free of charge, when necessary to ensure that people with disabilities have an equal opportunity to communicate effectively with us. Your health plan also provides language assistance services, free of charge, for people with limited English proficiency. If you need these services, call Customer Service at the phone number on your benefit ID card.

If you believe that we have 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 Grievance Department (write to the address listed in your Evidence of Coverage). You can also file a grievance by phone by calling the Customer Service phone number listed on your benefit ID card (TTY: 711). If you need help filing a grievance, call Customer Service Department at the phone number on your benefit ID card.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf.

ESPAÑOL (SPANISH): Si habla un idioma que no sea inglés, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web o llame al número de teléfono que figura en este documento.

繁體中文 **(CHINESE):** 如果您使用英文以外的語言，我們將提供免費的語言協助服務。請瀏覽我們的網站或撥打本文件中所列的電話號碼。