OhioRISE, specialized behavioral healthcare from Aetna Better Health® of Ohio

Authorization to Release Protected Health Information (PHI)

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 **authorization** to share your PHI. We will only give out the PHI to the people or agencies that you list.

1. Who is the OhioRISE Member?

First name	Last name	Middle initial
Member ID number	Birth date *(MM/DD/YYYY)*	Phone number
Street		
City, state, ZIP code		

2. Aetna may use or give out protected health information (PHI) for the purposes outlined in their notice of privacy practices, as well as to any person authorized via this form. Who can the PHI be given to?

Any class or category of persons and/or entities affiliated with the care I received pursuant to coverage under my Ohio Department of Medicaid (ODM) plan, including to ODM and those health plans, care coordination entities, care management entities, physicians, providers and healthcare professionals, hospitals, clinics, laboratories, pharmacies, medical facilities, insurers, or other home healthcare agencies that have provided payment, treatment, or health care services to me or on my behalf.

First Name	Last Name	Date of Birth (DOB)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. What PHI can we share?

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

- ☑ Any information requested
- ☑ Health (medical, dental, pharmacy, vision)
- ☑ Care coordination records
- ☑ Patient management records

Sensitive Information:
(this information may include diagnosis and/or treatment information)

- ☑ Substance use disorder (alcohol/drug)
- ☑ HIV/AIDS
- ☑ Sexually transmitted diseases
- ☑ Behavioral health/Mental health (but NOT psychotherapy notes).
- ☐ Other (please explain) _____

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

4. Why are you giving out this PHI?

Reason/Purpose:

To provide caregivers, care managers, legal representatives, and other individuals indicated above the appropriate levels of information required via FamilyCare Central and other means.

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

My authorization is good from:

_____ to _____

MM/DD/YYYY MM/DD/YYYY

By signing below, I understand and agree:

- I can take back my **authorization** by writing to the address on this form.
- If I take back my **authorization,** it won't take back the protected health information (PHI) Aetna Better Health of Ohio already shared.
- 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 **authorize** to share may include:
  - Health condition and treatment information
  - Chronic diseases
  - Behavioral/Mental health conditions
  - Substance use disorder diagnosis or treatment (alcohol/drug)
  - Transmissible diseases, sexually transmitted diseases (HIV/AIDS), and genetic marker information.
- I can get a copy of this **authorization** by writing to the address on this form.
- Aetna will not share my PHI with whom I named unless I sign this form.

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 protected health information (PHI) being shared may include one or more of the below conditions:
  - Behavioral/Mental health conditions
  - Substance use disorder diagnosis or treatment (alcohol/drug)
  - 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) Date of Birth (DOB):	

Authorized representative means you have appropriate written proof that you can act for this person. If the member is less than 18 years old, a parent or guardian should sign for the minor. If you are an authorized representative signing this form, you must send appropriate written proof you can act for this person.

Do you have questions? We can help. Call Aetna at **1-833-711-0773** **(TTY: 711)**.

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