



Removal of Authorization Previously Given to Aetna

Protected Health Information (PHI) means information about your health. Federal and state laws protect the privacy of your PHI. The laws say we cannot give anyone other than your doctors and others who may be taking care of you your PHI unless you say it is **OK**. By signing this paper, you give us your **OK** to remove the people or agencies you previously named to receive your PHI.

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. What authorization do you want removed? *(Check the correct box.)*

☐ Your OK for Aetna to give your PHI to other people or agencies.
☐ Your OK for Aetna to request your PHI from other people or agencies.

3. Who are the people or agencies you want removed from getting your PHI?

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

4. Important: By signing below, I understand and agree:

• By removing my OK, it will not effect actions Aetna took before getting this request. • I can get a copy of this request by writing to the address on this form.	
Signature of member or legal representative	Date
Print name of member's legal representative <i>(if applicable)</i>	

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:** [1-800-279-1878](tel:1-800-279-1878) (TTY [711](tel:711)).

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: [1-859-280-1272](tel:1-859-280-1272)