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

"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)

☐ Long term care ☐ 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) _____

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

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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
  - 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 **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 (alcohol/drug)
  - Behavioral/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)	Date of Birth (DOB)

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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 Better Health of WV Member Services at **1-888-348-2922** (TTY: **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: **859-280-1272**

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