aetna®

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.

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:

Tarrant Service Area: 1-800-306-8612
Bexar Service Area: 1-800-248-7767.

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**

Nondiscrimination Notice

Aetna complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card or **1-800-385-4104**.

If you believe that Aetna has 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 Civil Rights Coordinator at:

Address:	Attn: Civil Rights Coordinator 4500 East Cotton Center Boulevard Phoenix, AZ 85040
Telephone:	**1-888-234-7358 (TTY 711)**
Email:	MedicaidCRCoordinator@aetna.com

You can file a grievance in person or by mail or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Multi-language Interpreter Services

ENGLISH: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card or **1-800-385-4104** (TTY: **711**).

SPANISH: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que aparece en el reverso de su tarjeta de identificación o al **1-800-385-4104** (TTY: **711**).

VIETNAMESE: CHÚ Ý: nếu bạn nói tiếng việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi số có ở mặt sau thẻ id của bạn hoặc **1-800-385-4104** (TTY: **711**).

CHINESE: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電您的 ID 卡背面的電話號碼或 **1-800-385-4104** (TTY: **711**)。

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드 뒷면에 있는 번호로나 **1-800-385-4104** (TTY: **711**) 번으로 연락해 주십시오.

ARABIC: ملحوظة: إذا كنت تتحدث باللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل على الرقم الموجود خلف بطاقتك الشخصية أو عل **1-800-385-4104**(للصم والبكم: **711**)

URDU: توجہ دیں: اگر آپ اردو زبان بولتے ہیں، تو زبان سے متعلق مدد کی خدمات آپ کے لئے مفت دستیاب ہیں - اپنے شناختی کارڈ کے پیچھے موجود نمبر پر یا **1-800-385-4104** (TTY: **711**) پر رابطہ کریں۔

TAGALOG: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tumawag sa numero na nasa likod ng iyong ID card o sa **1-800-385-4104** (TTY: **711**).

FRENCH: ATTENTION: si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro indiqué au verso de votre carte d'identité ou le **1-800-385-4104** (ATS: **711**).

HINDI: ध्यान दें: यदि आप हिंदी भाषा बोलते हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। अपने आईडी कार्ड के पृष्ठ भाग में दिए गए नम्बर अथवा **1-800- 385-4104** (TTY: **711**) पर कॉल करें।

PERSIAN: اگر به زبان فارسی صحبت می کنید، به صورت رایگان می توانید به خدمات کمک زبانی دسترسی داشته باشید. با شماره درج شده در پشت کارت شناسایی یا با شماره **1-800-385-4104** (TTY: **711**) تماس بگیرید.

GERMAN: ACHTUNG: Wenn Sie deutschen sprechen, können Sie unseren kostenlosen Sprachservice nutzen. Rufen Sie die Nummer auf der Rückseite Ihrer ID-Karte oder **1-800-385-4104** (TTY: **711**) an.

GUJARATI: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડની પાછળ આપેલા નંબર પર અથવા **1-800-385-4104** પર કૉલ કરો (TTY: **711**).

RUSSIAN: ВНИМАНИЕ: если вы говорите на русском языке, вам могут предоставить бесплатне услуги перевода. Позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки, или по номеру **1-800-385-4104** (TTY: **711**).

JAPANESE: 注意事項:日本語をお話になる方は、無料で言語サポートのサービスをご利用いただけます。IDカード裏面の電話番号、または**1-800-385-4104** (TTY: **711**)までご連絡ください。

LAOTIAN: ເຊີນຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຫາເບີໂທທີ່ຢູ່ດ້ານຫຼັງບັດປະຈຳຕົວຂອງທ່ານ ຫຼື **1-800-385-4104** (TTY: **711**).

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