



Protected Health Information (PHI) Access Request

ECHS Category - PHIA

**Protected Health Information (PHI) means information about your health.
This form must be completed and signed to process this request.**

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. Description of a PHI Report

Once we get this signed request form, we will provide you with a PHI Report. The report will have the last 24 months of PHI data that we have. If you want PHI for different dates, fill in the dates below.

From: _____ To: _____

If you have Long Term Care (LTC) benefits and want that information, check the correct box below.

I want the report to include LTC information I only want LTC information in the report.

3. Where do you want this PHI Report to be sent?

Who is receiving this PHI Report? <input type="checkbox"/> Member <input type="checkbox"/> Member's Legal Representative <input type="checkbox"/> Member's Natural or Adoptive Parent
Print name of recipient
Recipient's street
City, state, ZIP code

Important Information:

- By signing this form, I allow Aetna to give PHI about the Member named in **Section 1** to the recipient named in **Section 3**.
- This approval is only for this request.
- This report may include information about chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, sexually-transmitted diseases, HIV/AIDS, and/or genetic marker.
- This PHI Report does not include psychotherapy notes.
- Information in this report could be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws.

4. 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)	

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

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)

Please allow 30 days for our response.