

## Authorization for Release of Protected Health Information (PHI)

My health record is private and is known under the law as “Protected Health Information” (PHI).

By completing and signing this form, I, or my legal representative, agree to allow Aetna to share my PHI with the people or companies listed below. By Aetna, I also mean the company’s subsidiaries, affiliates, employees, agents and subcontractors. PLEASE COMPLETE ALL SECTIONS.

### 1. My information

My first name		Last name	Middle initial
My member ID number	My birth date (MMDDYYYY)		My phone number
My street		My city, state, ZIP code	

### 2. Aetna can share my PHI with the following people or companies:

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

### 3. Aetna can share ONLY my records chosen below.

<p>You must check any and all information that you want to be shared. This authorization cannot be used to share psychotherapy notes.</p> <p><input type="checkbox"/> Health (medical, dental, pharmacy, vision and flexible spending account information)</p> <p><input type="checkbox"/> Long term care    <input type="checkbox"/> Patient management records</p> <p><input type="checkbox"/> Substance use disorder (alcohol/drug)    <input type="checkbox"/> HIV/AIDS    <input type="checkbox"/> Sexually transmitted diseases</p> <p><input type="checkbox"/> Behavioral health/Mental health (but NOT psychotherapy notes).</p> <p><input type="checkbox"/> Other sensitive services (such as gender affirming care or sexual or reproductive health)</p> <p><input type="checkbox"/> Other (please explain) _____</p>
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### 4. By signing this form I authorize Aetna to disclose information below for the following purpose.

<p><u>Check one of the following options:</u></p> <p><input type="checkbox"/> At my request – no specific purpose    <input type="checkbox"/> Specific purpose: _____</p>
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### 5. This form will be valid for 1 year unless a shorter time period is listed below.

My authorization is valid from		to	
_____	MM/DD/YYYY	_____	MM/DD/YYYY

**6. By signing below, I understand and agree:**

- My PHI that I agree to share may be sensitive. It may include diagnosis and treatment information. It may cover chronic diseases, behavioral health conditions and alcohol or drug abuse. It may cover communicable diseases, sexually transmitted diseases such as HIV/AIDS, and genetic marker information.
- Whoever gets my PHI may share it with others. That means federal or state privacy laws may no longer protect my PHI.
- I can get a copy of this authorization form that I have signed by sending Aetna a signed request using the address at the bottom of this form.
- Aetna will not release my PHI to the individual(s) or company(ies) named in Section 2 unless I sign this form.
- I can cancel or change my decision any time. I can do this by writing to Aetna, using the address at the bottom of this form.
- If I do cancel my permission, it will not affect actions Aetna took before getting my request.
- My ability to enroll won't change if I do not sign this form.
- My eligibility for benefits and services won't change if I do not sign this form.

**ATTENTION:**

- My signature is required if any of the below apply:
- I am 18 years of age or older
  - I am a minor under the age of 18 and I am either married or I am emancipated
  - The information being disclosed pertains to drug or alcohol treatment
  - The information being disclosed pertains to one of the following conditions and my state allows me to be treated even if my parents or legal guardian do not agree with my decision:
    - Mental health
    - Sexually transmitted disease (including HIV/AIDS)
    - Reproductive health (including contraception, prenatal care and abortion)
    - General medical and dental health

**7. My signature or my legal representative's signature**

Signature	Date
Print name	
If a legal representative signed this form, describe the relationship: (parent, legal guardian, Power of Attorney, personal representative)	

- If this request is being signed by the member's legal representative, you must provide legal documentation authorizing you to act on the member's behalf (e.g., legal guardianship, power of attorney, personal representative).
- If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

Please sign and return this completed form to:

**HIPAA Member Rights Team  
PO Box 14079  
Lexington, KY 40512-4079**

Or you can fax it to: **859-280-1272**

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779), [1-800-648-7817](tel:1-800-648-7817), TTY: [711](tel:711),

Fax: [859-425-3379](tel:859-425-3379) (CA HMO customers: [860-262-7705](tel:860-262-7705)), [CRCordinator@aetna.com](mailto:CRCordinator@aetna.com).

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

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Igbo	Inweta enyemaka asụsụ na akwughi ụgwọ obula, kpọọ nọmba nọ na kaadi njirimara gi
Ilocano	Tapno maakses dagiti serbisio ti pagsasao nga awanan ti bayadna, awagan ti numero nga adda ayan ti ID kardmo.
Indonesian	Untuk mengakses layanan bahasa tanpa dikenakan biaya, silakan hubungi nomor telepon di kartu asuransi Anda.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Karen	လၢတၢ်ကမၤကိၣ်တၢ်မၤတၢ်အံၤတၢ်ဖံးတၢ်မၤတၢ်ဖၣ် လၢတၢ်အံၤတၢ်ဖံးအံၤလၢတၢ်ကမၤကိၣ်တၢ်မၤတၢ်အံၤတၢ်ဖံးတၢ်မၤတၢ်ဖၣ် (၅၅) အလံၤတၢ်ကမၤကိၣ်
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Kru-Bassa	I nyuu kosna mahola ni language services ngui nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matibla
Kurdish	بۆ دەستگیراگیشتن به خزمەتگوزاری زمان بەبێ تێچوون بۆ تو، پەیوەندی بکە بە ژمارەی سەر ئای دی (ID) کارتێ خۆت.
Lao	ເພື່ອຂ້າຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທລະສັບໃນບັດປະຈຳຕົວຂອງທ່ານ.
Marathi	आपल्याला कोणत्याही शुल्काशिवाय भाषा सेवांपर्यंत पोहोचण्यासाठी, आपल्या ID कार्डवरील क्रमांकावर फोन करा.
Marshallese	Ñan bōk jipañ kōn kajin ilo an ejjeļok wōņean ñan kwe, kwōn kallok nōmba eo ilo kaat in ID eo aņ.
Micronesian-Ponapean	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T'áa ni nizaad k'ehjí bee níká a' doowoł doo bááh ílínígóó naaltsoos bee atah nílǫjgo nanitinígíí bee néého' dólzinígíí béésh bee hane'í biká'ígíí áají' hólne'.
Nepali	भाषासम्बन्धी सेवाहरूमाथि निःशुल्क पहुँच राख्न आफ्नो कार्डमा रहेको नम्बरमा कल गर्नुहोस्।
Nilotic-Dinka	Të kɔɔr yin ran de wëër de thokic ke cîn wëu kɔr keek tënɔŋ yin. Ke yin cɔl ran ye kɔc kuony në namba de abac tō në ID kard duɔn de tiit de nyin de panakim kōu.
Norwegian	For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫੋਨ ਕਰੋ।
Romanian	Pentru a accesa gratuit serviciile de limbă, apelați numărul de pe cardul de membru.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.

