aetna℠

# Authorization for Release of Protected Health Information (PHI)

ECHS Category - PHIA

I hereby authorize Aetna Life Insurance Company and any of its parents, subsidiaries, and affiliates (including, but not limited to Aetna Health Management, Inc., Aetna's affiliated HMOs and Aetna Integrated Informatics, Inc.) and their respective employees, agents and subcontractors, to disclose PHI concerning the Member identified below.

**I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY.**

***Please Print All Responses***

**Please submit a separate Authorization for Release of Protected Health Information for each Member for whom Aetna is being requested to disclose protected health information to a third party. If both sides of this form are not completed, as applicable, Aetna will be unable to process your request. Incomplete authorization requests will be returned.**

**1. Member Information**

| Last Name | | First Name | Middle Initial |
|---|---|---|---|
| I.D. Number | Social Security Number | Birth Date *(MM/DD/YYYY)* | Daytime Telephone Number *(include area code)* |
| Street Address | | City, State and ZIP Code | |

**2. Subscriber Information** *(The Subscriber is usually the Employee who obtains coverage for his or her family. Please complete this Section if the Subscriber is not the member whose records are being requested.) This Section does not apply to Long Term Care.*

| Last Name | | First Name | | Middle Initial |
|---|---|---|---|---|
| I.D. Number | Social Security Number | Birth Date *(MM/DD/YYYY)* | Daytime Telephone Number *(include area code)* | Employer |
| Street Address | | City, State and ZIP Code | | |

**3. I authorize the individual(s) or company(ies) identified below to receive PHI pertaining to the Member identified in Section 1 above.** [1]

| Individual or company authorized to receive PHI | | Daytime Telephone Number *(include area code)* |
|---|---|---|
| Street Address | City, State and ZIP Code | |
| Individual or company authorized to receive PHI | | Daytime Telephone Number *(include area code)* |
| Street Address | City, State and ZIP Code | |
| Individual or company authorized to receive PHI | | Daytime Telephone Number *(include area code)* |
| Street Address | City, State and ZIP Code | |

**4. Purpose(s) for this Authorization**

**The purpose of this authorization is to permit disclosure of any and all requests for PHI, as well as information pertaining to disability and life insurance products, to the individual(s) or company(ies) named in Section 3 above. NOTE: This form cannot be used to authorize release of psychotherapy notes.**

**If you prefer to authorize disclosure of only selected categories of information, please indicate below which types of information may be disclosed.**

☐ Health (This includes medical, dental, pharmacy, vision, and flexible spending account information)

☐ Behavioral Health (e.g., mental health, drug and alcohol abuse treatment, but ***not*** psychotherapy notes)

☐ Disability ☐ Life Insurance ☐ Long Term Care

**This authorization will be in effect for one year from the date signed, unless you indicate a shorter period below.**

_____ through _____

mm/dd/yyyy mm/dd/yyyy

[1] **NOTICE TO RECIPIENT(S) OF INFORMATION (Section 3. above):**
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.

**4. Purpose(s) for this Authorization (continued)**

**This authorization will apply to all PHI maintained by Aetna, unless you specify certain categories below.**

Description of the information to be released or disclosed: (*check all that are appropriate*)

- ☐ Application or enrollment information
- ☐ Claim records
- ☐ Claim status
- ☐ Patient management records
- ☐ Other: *(please specify)* _____

**5. IMPORTANT: Your signature below means that you understand and agree to the following:**

- The PHI disclosed pursuant to this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, sexually-transmitted diseases, HIV/AIDS, and/or genetic marker information. These records will be included in the information we will make available to the individual(s) or company(ies) identified in Section 3 above.
- Information disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy regulations. ***Oklahoma Residents***: You may have additional protections under Section 1-502.2 of the Oklahoma Statutes if the type of information to be released relates to HIV/AIDS and/or sexually-transmitted disease information.
- If we receive requests for copies of claims and encounter information from the individual or company you have named in Section 3, we may charge a reasonable fee (except where prohibited by law) to defray our copying and mailing costs.
- Your ability to enroll in an Aetna plan, and your eligibility for benefits and payment for services, will not be affected if you do not sign this form. (However, without your signature, your request to release information to the individual(s) named in Section 3 above will not be honored.)
- You may receive a copy of this signed form if you ask for it by writing to the address listed at the bottom of this page.
- You may revoke this authorization at any time by notifying Aetna in writing at the address below. Revoking this authorization will not have any effect on actions that Aetna took in reliance on the authorization before we received the notification.

**6. Signature of Member or Member's Legal Representative.**

| Minors must sign this form below ***if*** (check applicable box): | All others must sign this form below as (check applicable box): |
|---|---|
| 1. ☐ the minor is married or emancipated **or**,<br>2. ☐ the information being authorized for release pertains to drug or alcohol treatment **or**,<br>3. ☐ the information authorized for release pertains to one of the following conditions ***and*** applicable state law permits the minor to receive treatment for these conditions without consent of parent/legal guardian:<br>a. mental health<br>b. sexually transmitted diseases (including HIV/AIDS)<br>c. reproductive health (including contraception, prenatal care and abortion)<br>d. general medical and dental health. | 4. ☐ the member or member's legal representative **or**,<br>5. ☐ the parent/legal guardian of unemancipated minor, unless minor has signed at left, box 2 has been checked, and state law requires signature of parent/legal guardian for drug or alcohol treatment.<br>6. ☐ the parent/legal guardian of unemancipated minor, unless minor has signed at left ***and*** box 3 at left has been checked. |
| Signature / Date | Signature / Date |
| Print Name | Print Name |

**If the person signing this Authorization is not the Member,** describe relationship to the Member (i.e. Parent/Legal Guardian, Legal Representative):

If this authorization is being signed by the Member's Legal Representative, you must furnish a copy of the health care power of attorney, or other relevant document authorizing you to act on the Member's behalf.

**Return this completed form and relevant documentation, if required, to:**

**Aetna HIPAA Member Rights Team**
**PO Box 14079**
**Lexington, KY 40512-4079**
**Fax: (860) 907-3017**