Authorization for Release of Protected Health Information (PHI)

ECHS Category - PHIA

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 Banner | Aetna to share my PHI with the people or companies listed below. By Banner | 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. Banner | 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. Banner | Aetna can share ONLY my records chosen below.

You must check any and all information that you want to be shared. This authorization cannot be used to share psychotherapy notes.

- ☐ Health (medical, dental, pharmacy, vision and flexible spending account information)
- ☐ Long term care ☐ Patient management records
- ☐ Substance use disorder (alcohol/drug) ☐ HIV/AIDS ☐ Sexually transmitted diseases
- ☐ Behavioral health/Mental health (but NOT psychotherapy notes).
- ☐ Other sensitive services (such as gender affirming care or sexual or reproductive health)
- ☐ Other (please explain) _____

4. By signing this form I authorize Banner | Aetna to disclose information below for the following purpose.

Check one of the following options:

☐ At my request – no specific purpose ☐ Specific purpose: _____

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 Banner|Aetna a signed request using the address at the bottom of this form.
- Banner|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 Banner|Aetna, using the address at the bottom of this form.
- If I do cancel my permission, it will not affect actions Banner|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 (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**

Nondiscrimination Notice

Banner|Aetna complies with applicable Federal civil rights laws and does not 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
1-800-648-7817, TTY: 711
Fax: 859-425-3379
E-mail: **CRCoordinator@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, 800-537-7697 (TDD).

Banner|Aetna is the brand name used for products and services provided by Banner Health and Aetna Health Insurance Company and Banner Health and Aetna Health Plan Inc. Health benefits and health insurance plans are offered and/or underwritten by Banner Health and Aetna Health Insurance Company and/or Banner Health and Aetna Health Plan Inc. (Banner|Aetna). Each insurer has sole financial responsibility for its own products. Banner Health and Aetna Health Insurance Company and Banner Health and Aetna Health Plan Inc. are affiliates of Banner Health and of Aetna Life Insurance Company and its affiliates (Aetna). Aetna and Banner Health provide certain management services to Banner|Aetna.

TTY: 711

To access language services at no cost to you, call the number on your ID card.

Para acceder a los servicios de idiomas sin costo, llame al número que figura en su tarjeta de identificación. (Spanish)

T'áá ni nizaad k'ehjí bee níká a'doowoł doo bą́ąh ílínígóó naaltsoos bee atah nílį́įgo nanitinígíí bee nééhoʼdólzinígíí béésh bee hane'í bikáá' áajį' hólne'. (Navajo)

如欲使用免費語言服務，請致電您 ID 卡上的電話號碼 (Chinese)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số điện thoại ghi trên thẻ ID (Nhận dạng) của quý vị. (Vietnamese)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقتك الشخصية. (Arabic)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tawagan ang numero sa inyong ID card. (Tagalog)

무료 언어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오. (Korean)

Afin d'accéder aux services langagiers sans frais, veuillez composer le numéro inscrit sur votre carte d'identité. (French)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an. (German)

Для получения бесплатной помощи переводчика позвоните по телефону, указанному на Вашей личной карточке медицинского страхования. (Russian)

言語サービスを無料でご利用いただくには、IDカードに記載の番号にお電話ください。(Japanese)

برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید. (Persian-Farsi)

ܟܝ ܡܨܝܬܘܢ ܬܠܒܘܢ ܥܠ ܝܠܦܢܘܬܐ ܕܬܘܪܓܡܐ ܕܠܫܢܐ ܡܓܢܐܝܬ، ܩܪܘܢ ܡܢܝܢܐ ܥܠ ܦܬܩܐ ܕܗܝܡܢܘܬܐ ܕܝܠܟܘܢ.
(Syriac-Assyrian)

Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici. (Serbo-Croatian)

หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน (Thai)