innovation HEALTH

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 Innovation Health to share my PHI with the people or companies listed below. By Innovation Health, 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. Innovation Health 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. Innovation Health 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 Innovation Health 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 Innovation Health a signed request using the address at the bottom of this form.
- Innovation Health 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 Innovation Health, using the address at the bottom of this form.
- If I do cancel my permission, it will not affect actions Innovation Health 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**

Innovation Health 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.

Innovation Health provides 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 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, 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).

Innovation Health® is the brand name used for products and services provided by Innovation Health Insurance Company or Innovation Health Plan, Inc. Innovation Health is an affiliate of Aetna Life Insurance Company and its affiliates (Aetna). Aetna provides certain management services to Innovation Health. Aetna is part of the CVS Health® family of companies.

TTY: 711

For language assistance in English call the number listed on your ID card at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación. (Spanish)

欲取得繁體中文語言協助，請撥打您 ID 卡上所列的號碼，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an. (German)

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للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني المذكور في بطاقتك التعريفية. (Arabic)

বাংলায় ভাষা সহায়তার জন্য আপনার আইডি কার্ডে যে নম্বরটি তালিকাভুক্ত রয়েছে বিনামূল্যে তাতে কল করুন। (Bengali)

(Hindi) **हिन्दी में भाषा सहायता के लिए, अपने आईडी कार्ड पर दिये गये नम्बर पर मुफ्त कॉल करें।**

Maka enyemaka asụsụ na Igbo kpọọnọmba edepụtara na kaadị ID gị na akwụghị ụgwọ ọ bụla. (Ibo)

한국어로 언어 지원을 받고 싶으시면 보험 ID 카드에 수록된 무료 통화번호로 전화해 주십시오. (Korean)

Bɛ̀ m̀ ké gbo-kpá-kpá dyé ɖé̱ Bǎsɔ́ɔ̀ wùɖù̱ǔn wɛ̃ɛ, ɖá nɔ̀bà bɛ́ ɔ céèà bó nì dyí-dyoìn-bɛ̃̀ɛ̃̀ kɔ̃ɛ bó pídyi. (Kru-Bassa)

برای راهنمایی به زبان فارسی، بدون هیچ هزینه ای با شماره ای که بر روی کارت شناسایی شما آمده است تماس بگیرید. انگلیسی (Persian)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру, указанному в вашей ID-карте удостоверения личности. (Russian)

اُردو میں لسانی معاونت کے لیے اپنے ID کارڈ پر درج نمبر پر مفت کال کریں۔ (Urdu)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số được ghi trên thẻ ID của quý vị. (Vietnamese)

Fún ìrànlọwọ́ nípa èdè (Yorùbá) pe nọmbà tí a kọ sórí káàdì ìdánimọ̀ rẹ lái san owó kankan rárá. (Yoruba)