aetna®

Money^2 for 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 Aetna to share my PHI with the company listed below. By Aetna, I also mean the company's subsidiaries, affiliates, employees, agents and subcontractors.

Please submit a separate Authorization form for each Member for whom Aetna is being requested to disclose PHI. If this form is not properly completed Aetna will be unable to process your request. Incomplete authorization requests will be returned.

PLEASE COMPLETE ALL 6 SECTIONS

1. My information

My first name	My last name	My middle initial
My member ID number	My birth date *(MMDDYYYY)*	My phone Number - -
My street	My city, state and ZIP Code	

2. I authorize the company identified below to receive my PHI including any sensitive claim information. [1]

Company authorized to receive PHI

Citibank, N.A. for Money^2 for Health (inclusive of affiliates, subsidiaries, subcontractors and vendors)

3. Purpose(s) for this Authorization

The purpose of this authorization is to permit disclosure of limited data elements (date of service, dollar amount, provider name, etc.) to the company named in Section 2 above to facilitate member claim payment.
NOTE: This form cannot be used to authorize release of psychotherapy notes.
This authorization will apply to all PHI maintained by Aetna.

4. This form will be valid for one year unless a shorter time period is listed below.

My authorization is valid from: _____ to _____

MM/DD/YYYY MM/DD/YYYY

[1] **NOTICE TO RECIPIENT(S) OF INFORMATION (Section 2. above):**
Provider information disclosed to you may infer that certain conditions, such as treatment for alcohol or drug abuse, HIV/AIDS and other sexually transmitted diseases, behavioral health, and genetic marker information exist. This 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.

5. By signing below, I understand and agree:

- My PHI made available to the company identified in Section 2 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 company 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.
- Oklahoma residents may have more protection under Section 1-502 of the state statute. This law pertains to HIV/AIDS and/or sexually transmitted disease.

ATTENTION:

My signature is required if I am 12 years of age or older	
6. By signing this form, I am authorizing the transmittal of my claim information and PHI for the purposes of claim payment through Money^2 for Health, and I acknowledge that this claim information and PHI may be viewed by the subscriber during the claim payment process.	
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).

Please sign and return this completed form to:

Aetna's HIPAA Member Rights Team
PO Box 14079
Lexington, KY 40512-4079

Or you can fax it to: (859) 280-1272