MERITAIN HEALTH
An Aetna Company

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 Meritain Health and any of its parents, subsidiaries and affiliates, and their respective employees, agents and subcontractors, to share my PHI with the people or companies listed below.

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY.

Please submit a separate Authorization for Release of Protected Health Information (PHI) for each plan member for whom Meritain Health is being requested to disclose PHI to a third party. If both sides of this form are not completed, as applicable, Meritain Health will be unable to process your request. Incomplete authorization requests will be returned.

Please print all responses

1. Member Information				
Last Name		First Name		Middle Initial
ID Number	Group Number or Group Name	Birth Date *(MM/DD/YYY)*	Phone Number *(Including Area Code)*	
Street Address		City	State	Zip Code

2. Employee Information *(Please complete this section if the employee is not the member whose records are being requested.)*				
Last Name		First Name		Middle Initial
ID Number	Group Number or Group Name	Birth Date *(MM/DD/YYY)*	Phone Number *(Including Area Code)*	
Street Address		City	State	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.*			
Individual or Company Authorized to Receive PHI			Phone Number *(Including Area Code)*
Street Address	City	State	Zip Code
Individual or Company Authorized to Receive PHI			Phone Number *(Including Area Code)*
Street Address	City	State	Zip Code
Individual or Company Authorized to Receive PHI			Phone Number *(Including Area Code)*
Street Address	City	State	Zip Code

4. Purpose(s) for this Authorization

I only want to share the PHI I havechecked below. This authorization cannot be used to share psychotherapy notes. (Check all that are appropriate)

❑ Any information requested

❑ 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 Benefits ❑ Long term care ❑Patient management records ❑Application or enrollment information
❑Claim status ❑ Claim records
❑ Other (please explain) _____

This authorization will be valid for 1 year from the date signed, unless you indicate a shorter period below.

_____ **through** _____
MM/DD/YYYY ***MM/DD/YYYY***

***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.

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

- My PHI that I agree to share may be sensitive. It 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.
- Whoever gets my PHI may share it with others. That means federal or state privacy laws may no longer protect my PHI. ***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/ 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.
- I can get a acopy of this authorization form that I have signed by sending Meritain Health a signed request using the address at the bottom of this page.
- Your ability to enroll in a Meritain Health 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 cancel or change this authorization at any time by notifying Meritain Health in writing at the address below. Revoking this authorization will not have any affect on actions that Meritain Health took before getting my request..

6. Signature of Member or Member's Legal Representative

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 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

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 provide the relevant legal document authorizing you to act on the Member's behalf (e.g. Power of Attorney, Legal Guardianship, Executor of Estate).

If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

Return this completed form and relevant documentation, if required, to:
Meritain Health
Attn: HIPAA Compliance Officer
P.O. Box 1671
Amherst, NY 14226-7671

Or you can fax it to: 716.319.5589