aetna℠

Protected Health Information (PHI) Access Request Form

This form needs to be completed and signed, where appropriate, for Aetna to process the request. If you want to receive information for more than one Member, please submit a separate, completed form for each Member.

1. Member Information (Information About Person Whose Records are Being Requested.)

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)*
Street Address		City, State and ZIP Code	

3. Description of PHI Access Reports

Upon receipt of this signed PHI Access Request Form, Aetna will provide a PHI Access Report containing the most recent 24 months of on-line medical, dental, and pharmacy claim data that we have in our possession. If this PHI Access Report is sufficient, you do not need to select any of the options in this Section but you must complete Section 4 or 5, whichever applies to this request. Indicate below if you have a more specific request.

If instead of the most recent 24 months of claim data, you prefer for the PHI Access Report to include claim data over a different period, please indicate the date range below:

From: _____ To: _____

If you receive reimbursements for medical expenses through a Flexible Spending Account (FSA) administered by Aetna and would like a report of FSA payments sent, please check the appropriate box below, complete the rest of this PHI Access Request Form (including the necessary signature in Section 4 or 5, whichever applies), and, in addition, have the Subscriber or the Subscriber's Legal Representative sign the authorization in Section 4 or 5, as appropriate.

☐ I want the PHI Access Report to include FSA information ☐ I only want FSA information sent

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If you receive benefits from Aetna's Long Term Care (LTC) plan and would like LTC information sent, please check the appropriate box below:

☐ I want the PHI Access Report to include LTC information ☐ I only want LTC information sent

Important Notice to Individual(s) signing this PHI Access Request Form:

- The PHI Access Report provided in response to this request may include diagnosis and treatment information, such as information on chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, sexually-transmitted diseases, HIV/AIDS, and/or genetic marker information.
- Any requested Flexible Spending Account (FSA) information will include information for all of the Subscriber's covered dependents.

4. If the PHI Access Report is to be sent to the Member, the Member's Legal Representative or the Member's Parent if the Member is an unemancipated minor child, the recipient must complete Section 4.

The recipient of the PHI Access Report is:

☐ Member ☐ Member's Legal Representative

☐ Member's Natural or Adoptive Parent (authorized by law to act on behalf of the unemancipated minor child identified in Section 1)

Signature of Recipient	Date
Print Name of Recipient	
Recipient's Street Address	City, State and ZIP Code
Signature of Subscriber or Subscriber's Legal Representative ***(required if FSA information is to be included)***	Date
Print Name of Subscriber's Legal Representative *(if applicable)*	

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

5. Authorization for Release of PHI (to be completed if the PHI Access Report is to be sent to someone other than the Member, the Member's Legal Representative, or the Member's Parent if the Member is an unemancipated minor child)

I hereby authorize Aetna Life Insurance Company and any of its parents, subsidiaries, or other 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 protected health information about the Member specified in Section 1 of this form to the authorized recipient designated below. This authorization applies only to fulfilling this request for access to PHI. Payment and eligibility for benefits do not depend on whether I sign this form. This authorization may be revoked by providing written notice to Aetna at the address in Section 6 below. Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy regulations.

Signature of Member, Member's Legal Representative, or the Member's Natural or Adoptive Parent (authorized by law to act on behalf of the unemancipated minor identified in Section 1)	Date
Print Name of Member, Member's Legal Representative, or Member's Parent	
Signature of Subscriber or Subscriber's Legal Representative ***(required if FSA information is to be included)***	Date
Print Name of Subscriber's Legal Representative *(if applicable)*	

Authorized Recipient's Last Name	First Name	Middle Initial
Authorized Recipient's Street Address	City, State and ZIP Code	

6. How to Return This Form

Return this completed form to: Aetna Legal Support Services
151 Farmington Avenue, RT65
Hartford, CT 06156-9998
Fax: 860-907-3017

Please allow 30 days for our response.