Authorization for Use or Disclosure of Protected Health Information (PHI)

My health record is private and is known under the law as "Protected Health Information" (PHI). As required by the Health Insurance Portability and Accountability Act (HIPAA), The Cleveland Clinic/Akron General Employee Health Plan (EHP), Aetna, in addition to Healthy Choice and EHP Medical and Pharmacy Management Departments, may only use and disclose your PHI as provided in the applicable Notice of Privacy Practices. Your signature on this form indicates that you are giving permission for additional use or disclosure of your health information, as described below.

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. **I Authorize the use or disclosure of my PHI, as detailed below, by Aetna, EHP, EHP Medical, and Pharmacy Management Departments by/to the following individual or entity:**

Person or Company Name	Phone Number
Street	City, State, ZIP Code

3. **I Authorize the disclosure of ONLY those records I have chosen below:**

I only want to share the PHI I have checked below. This authorization cannot be used to share psychotherapy notes.

☐ Any information requested
☐ Health (medical, dental, pharmacy, vision, and flexible spending account information)
☐ Long term care ☐ Patient management records ☐ Healthy Choice

Sensitive Information: (this information may include diagnosis and/or treatment information)

☐ Substance use disorder (alcohol/drug) ☐ HIV/AIDS ☐ Sexually transmitted diseases
☐ Behavioral health/EAP (but NOT psychotherapy notes)
☐ Other (please explain) ______

4. **By signing this form, I Authorize disclosure of the information above for the following reason or purpose:**

Check one of the following options:
☐ At my request – no specific purpose ☐ Specific purpose: ______________________

5. **This form will be valid for one (1) year unless a shorter time period is listed below.**

---Completion of this section is not required---

My authorization is valid from:

________________________________ to ______

MM/DD/YYYY	MM/DD/YYYY

6. By signing below, I understand and agree:

- The PHI I agree to share may be sensitive and 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.
- It is possible that whoever receives my PHI could share it with others and federal or state privacy laws may no longer offer legal protections.
- The entities noted in Section 2, above, will not release my PHI unless I sign this form or unless otherwise permitted/required to do so. I can cancel or change my decision any time. I must do this in writing, using the address at the bottom of this form.
- If I do cancel my permission, it will not affect actions taken prior to receiving my request.
- I may not be denied treatment and my payment for health care services, enrollment, or eligibility for health care benefits won't change if I do not sign this form.
- I may get a copy of this authorization form by sending a signed request using the address at the bottom of 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: (i.e. 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:

Aetna's Concierge Team
ClevelandClinic@aetna.com