aetna®

Request for an Accounting of Disclosures of Protected Health Information (PHI)

ECHS Category - PHIA

Protected Health Information (PHI) means information about your health. This form must be completed and signed to process this request.

1. Who is the Medicaid Member?

First name	Last name	Middle initial

Member ID number	Birthdate *(MM/DD/YYYY)*	Phone number

Street

City, state, ZIP code

2. Description of the Accounting Report

Once we get this signed request form, we will send you the Accounting Report.
The disclosures on the report are for reasons other than "treatment," "payment," or "health care operations."

3. Accounting Report time period cannot be longer than six (6) years from the request date.

My request is for the dates below:

_____ to _____

MM/DD/YYYY MM/DD/YYYY

4. Where do you want this Accounting Report to be sent?

Who is receiving this Accounting Report?

☐ Member ☐ Member's Legal Representative ☐ Member's Natural or Adoptive Parent

Print name of recipient

Recipient's street address

City, state, ZIP code

Important Information:

- By signing this form, I allow **Aetna Better Health of New Jersey** to give an Accounting of Disclosures of PHI Report about the Member named in **Section 1** to the recipient named in **Section 4**.
- This approval is only for this request.
- Information in this report could be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws.
- Disclosures older than six years from when this request was made will not be included.

5. Signature of Member or Authorized Representative

Signature	Date
Print name	
If a legal representative signed this form, describe the relationship: (parent, legal guardian, Power of Attorney, personal representative)	

Authorized Representative means you have legal proof that you can act for this person.
A representative signs for a person who cannot legally sign on his or her own. If the member is less than 18 years old, a parent, or guardian should sign for the minor. If you are a representative signing this form you must send legal proof you can act for this person.

Do you have questions? We can help. **Call Member Services at: 1-855-232-3596 (TTY 711).**

Please sign and return this completed form to: **Aetna HIPAA Member Rights Team**
PO Box 14079
Lexington, KY 40512-4079

Or you can fax it to: **859-280-1272**

Please allow 60 days for our response.

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ENGLISH: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card or **1-800-385-4104 (TTY: 711)**.

SPANISH: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que aparece en el reverso de su tarjeta de identificación o al **1-800-385-4104 (TTY: 711)**.

CHINESE: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電您的 ID 卡背面的電話號碼或 **1-800-385-4104 (TTY: 711)**.