



# Removal of Authorization Previously Given to Aetna

ECHS Category - PHIA

Protected Health Information (PHI) means information about your health. Federal and state laws protect the privacy of your PHI. The laws say we cannot give anyone other than your doctors and others who may be taking care of you your PHI unless you say it is **OK**. By signing this paper, you give us your **OK** to remove the people or agencies you previously named to receive your PHI.

### 1. Who is the Medicaid Member?

First name		Last name		Middle initial
Member ID number	Birth date (MM/DD/YYYY)		Phone number	
Street				
City, state, ZIP code				

### 2. What authorization do you want removed? (Check the correct box.)

<input type="checkbox"/>	Your <b>OK</b> for Aetna to give your PHI to other people or agencies.
<input type="checkbox"/>	Your <b>OK</b> for Aetna to request your PHI from other people or agencies.

### 3. Who are the people or agencies you want removed from getting your PHI?

Person or company name		Phone number
Street		
City, state, ZIP code		
Person or company name		Phone number
Street		
City, state and ZIP code		

**4. Important: By signing below, I understand and agree:**

<ul style="list-style-type: none"> <li>• By removing my <b>OK</b>, it will not affect actions Aetna took before getting this request.</li> <li>• I can get a copy of this request by writing to the address on this form.</li> </ul>	
Signature of member or legal representative	Date
Print name of member's legal representative <i>(if applicable)</i>	

**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 Aetna Better Health of California at: 1-855-772-9076.

**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**



## **AETNA BETTER HEALTH® OF CALIFORNIA**

### Nondiscrimination Notice

Discrimination is against the law. Aetna Better Health of California follows Federal civil rights laws. Aetna Better Health of California does not discriminate, exclude people, or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna Better Health of California provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Aetna Better Health of California 24 hours a day, 7 days a week by calling **1-855-772-9076**. Or, if you cannot hear or speak well, please call **TTY 711**.

#### **How to file a grievance**

If you believe that Aetna Better Health of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Aetna Better Health of California. You can file a grievance by phone, in writing, in person, or electronically:

**By phone:** Contact Aetna Better Health of California 24 hours a day, 7 days a week by calling **1-855-772-9076**. Or, if you cannot hear or speak well, please call **TTY 711**.

**In writing:** Fill out a complaint form or write a letter and send it to:

Aetna Better Health of California  
10260 Meanley Drive  
San Diego, CA 92131

**In person:** Visit your doctor's office or Aetna Better Health of California and say you want to file a grievance.

**Electronically:** Visit Aetna Better Health of California website at [aetnabetterhealth.com/california](http://aetnabetterhealth.com/california)

### **Office of Civil Rights**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

**By phone:** Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.

**In writing:** Fill out a complaint form or send a letter to:

**U.S. Department of Health and Human Services**  
**200 Independence Avenue, SW**  
**Room 509F, HHH Building**  
**Washington, D.C. 20201**

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**Electronically:** Visit the Office for Civil Rights Complaint Portal at  
<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.

## Multi-language Interpreter Services

**ENGLISH: ATTENTION:** If you speak 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**)。

**VIETNAMESE: CHÚ Ý:** nếu bạn nói tiếng việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi số có ở mặt sau thẻ id của bạn hoặc **1-800-385-4104** (TTY: **711**).

**TAGALOG: PAUNAWA:** Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tumawag sa numero na nasa likod ng iyong ID card o sa **1-800-385-4104** (TTY: **711**).

**KOREAN: 주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드 뒷면에 있는 번호로나 **1-800-385-4104** (TTY: **711**) 번으로 연락해 주십시오.

**ARMENIAN: Ուշադրություն:** Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարե՛ք ձեր ID քարտի հետևի մասում գտնվող հեռախոսահամարով կամ **1-800-385-4104** (TTY (հեռախոս)՝ **711**):

**PERSIAN:** اگر به زبان فارسی صحبت می کنید، به صورت رایگان می توانید به خدمات کمک زبانی دسترسی داشته باشید. با شماره درج شده در پشت کارت شناسایی یا با شماره **1-800-385-4104** (TTY: **711**) تماس بگیرید.

**RUSSIAN: ВНИМАНИЕ:** если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки, или по номеру **1-800-385-4104** (TTY: **711**).

**JAPANESE: 注意事項:**日本語をお話になる方は、無料で言語サポートのサービスをご利用いただけます。IDカード裏面の電話番号、または**1-800-385-4104** (TTY: **711**)までご連絡ください。

**ARABIC:** ملحوظة: إذا كنت تتحدث باللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل على الرقم الموجود خلف بطاقتك الشخصية أو على **1-800-385-4104** (للصم والبكم: **711**)

**PANJABI:** ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਵਿੱਚ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਆਪਣੇ ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਨੰਬਰ ਜਾਂ **1-800-385-4104** (TTY: **711**) 'ਤੇ ਕਾਲ ਕਰੋ।

**MON KHMER:** ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតលុយគឺអាចមានសំរាប់អ្នក។ ចូរទូរស័ព្ទទៅលេខនៅខាងក្រោយនៃអត្តសញ្ញាណប័ណ្ណ (ID Card) របស់អ្នក ឬ **1-800-385-4104** (TTY: **711**) ។

**HMONG:** LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau tus nab npawb xov tooj nyob rau sab qab ntwam koj daim ID lossis **1-800-385-4104** (TTY: **711**).

**HINDI:** ध्यान दें: यदि आप हिंदी भाषा बोलते हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। अपने आईडी कार्ड के पृष्ठ भाग में दिए गए नम्बर अथवा **1-800-385-4104** (TTY: **711**) पर कॉल करें।

**THAI:** ข้อควรระวัง: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทรติดต่อหมายเลขที่อยู่ด้านหลังบัตร ID ของคุณ หรือหมายเลข **1-800-385-4104** (TTY: **711**)