Aetna Better Health® of Kentucky
9900 Corporate Campus Drive, Suite 1000
Louisville, KY 40223

AETNA BETTER HEALTH® OF KENTUCKY

Privacy request form

Date of Request: _____

To request member information from Aetna Better Health® of Kentucky, please check one or more of the boxes below.

☐ Receive copy of privacy practices
☐ Receive claim records
☐ Change something in member records
☐ Receive list of organizations to which Aetna Better Health gives out member records
☐ Limit how Aetna Better Health uses and gives out member records

Member Name: _____ Date of Birth: _____ ID #: _____
Phone: (____) _____

Are you the member? ☐ Yes ☐ No If "NO", tell Aetna Better Health who you are by checking one of the boxes below. Please give Aetna Better Health copies of papers that show you have the right to make this request.

☐ I am the member's Dad/Mom or guardian
☐ I make health care decisions for the member
☐ The member has died, and I take care of his or her estate
☐ Other (explain) _____

Name of Requestor (if not member): _____

Please explain your request
Please tell us what you want to receive and why. You need to provide dates of service, names of providers, etc. Aetna Better Health may charge you to receive copies of member records or a list of people and companies to which we give out member records. You need to tell Aetna Better Health if you cannot pay any fee.

_____

Where do you want the records sent

Address: _____

Street **City,State** **Zip**

I (the member or person acting for the member) agree to the following:

- I may authorize Aetna Better Health to use or give out member records. When I give an approval, Aetna Better Health will give out member records to a person or company.
- I know that member records can't always be kept safe under privacy laws. I know a person or company that receives member records can give them out again.
- I may take back this authorization by submitting to Aetna Better Health a request in writing.
- I may not be allowed to take back an authorization in some cases. I can learn more about this in the Aetna Better Health's Notice of Privacy Practices.
- This authorization will end in twelve (12) months from the date of signature.
- If I want this authorization to end before this date, I will tell Aetna Better Health when and the reason I want it to end. Use the space below to explain:

  _____

- I have read and understand this form.
- I am entitled to receive a copy of this form.

_____

If member - Signature of member DATE

_____

If provider - Signature of provider

Please send this Privacy Request Form to:

Aetna Better Health of Kentucky
9900 Corporate Campus Drive, Suite 1000
Louisville KY 40223

If you have any questions or comments call Aetna Better Health of Kentucky at **1-855-300-5528, (TTY: 711 or TDD: 1-800-627-4702)**, Monday – Friday, 7 a.m. to 7 p.m. ET.

To receive a translated copy of this document, call Member Services at **1-855-300-5528**. Para recibir una copia traducida de este documento, llame al servicio para miembros al **1-855-300-5528**.