

# Authorization to Release Psychotherapy Notes

Use this form if you want your mental health care provider to share your psychotherapy notes with Aetna Better Health of Oklahoma.

Psychotherapy notes are made by your mental health care provider. These notes are records of your talks with your mental health care provider during counseling sessions. Your mental health care provider keeps these notes separate from your medical records.

## 1. Who is the SoonerSelect Member?

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

## 2. I OK this Mental Health Care Provider to share my psychotherapy notes.

Mental Health Care Provider	Phone number
Street	
City, state, ZIP code	

## 3. I OK this Person or Company to receive my psychotherapy notes.

Person or company name <b>Aetna Better Health<sup>1</sup>,</b>	Phone number
Street	
City, state, ZIP code	

### <sup>1</sup> NOTICE TO RECIPIENT(S) OF INFORMATION:

Information disclosed to Aetna Better Health pertaining to certain conditions, such as treatment for alcohol or drug abuse, HIV/AIDS and other sexually transmitted diseases, behavioral health, and genetic marker information is protected by various federal and state laws which prohibit any further disclosure of this information by Aetna Better Health without the express written consent of the person to whom it pertains or as otherwise permitted by such laws. Any unauthorized further disclosure in violation of state or federal law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient consent for release of these types of information. The federal rule at 42 CFR Part 2 restricts use of the information disclosed to criminally investigate or prosecute any alcohol or drug abuse patient.

**4. Why are you giving out these psychotherapy notes?**

Reason/Purpose:

My **OK** is to disclose psychotherapy notes **only**. I understand that these notes may have information on medical care or treatment for substance abuse. Also, information about acts of domestic abuse, or HIV/AIDS or other communicable or sexually transmitted diseases. And any treatment that may have been given by other health care providers.

**5. The psychotherapy notes I OK are for the following dates of service:**

\_\_\_\_\_

\_\_\_\_\_

**By signing below, I understand and agree:**

- I can take back my **OK** by asking my mental health care provider named in section 2.
- If you take back your **OK** it won't take back the PHI we already received.
- My chance to sign up for insurance will not change if I don't sign this form.
- Whoever gets my information may share it with others. That means laws may not be able to protect my information.
- I can get a copy of this **OK** by writing to the address in section 3 of this form.

**ATTENTION:**

- I must sign this form if any of the options below apply.
- I am 18 years of age or older.
  - I am under 18 years of age, and I am married or emancipated.
  - My state allows me to be treated even if my parents or legal guardian do not agree.
  - My psychotherapy notes being shared may include one of the below conditions:
    - Substance use disorder diagnosis or treatment
    - Mental health
    - Sexually transmitted disease (including HIV/AIDS)
    - Reproductive health (including contraception, prenatal care and abortion)
    - General medical and dental health

**6. 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)	

"Aetna" also includes Aetna's subsidiaries, affiliates, employees, agents and subcontractors.

**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 Oklahoma at [1-844-365-4385](tel:1-844-365-4385).

**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 Oklahoma

### Nondiscrimination Notice

Aetna complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Aetna:

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

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card or **1-800-385-4104**.

If you believe that Aetna 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 our Civil Rights Coordinator at:

Address: Attn: Civil Rights Coordinator  
4750 S. 44th Place, Suite 150  
Phoenix, AZ 85040-4015

Telephone: **1-888-234-7358 (TTY 711)**

Email: **MedicaidCRCoordinator@aetna.com**

You can file a grievance in person or by mail or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, **1-800-368-1019**, **1-800-537-7697 (TDD)**.

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

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, and its affiliates.

## Multi-language Interpreter Services

**ENGLISH:** ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1 844-365-4385 (TTY: 711)**.

**SPANISH:** ESPAÑOL: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1 844-365-4385 (TTY: 711)**.

**VIETNAMESE:** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1 844-365-4385 (TTY: 711)**.

**TRADITIONAL 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 **1 844-365-4385 (TTY: 711)**。

**KOREAN:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1 844-365-4385 (TTY: 711)**.

**GERMAN:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1 844-365-4385 (TTY: 711)**.

**Arabic:** ملاحظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1 844-365-4385 (TTY: 711)**.

**HMONG:** LUS CEEV: Yog tias koj hais Lus Hmoob, ces yuav muaj kev pab txhais lus pub dawb rau koj. Hu rau **1 844-365-4385 (TTY: 711)**.

**TAGALOG:** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1 844-365-4385 (TTY: 711)**.

**FRENCH:** ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1 844-365-4385 (TTY: 711)**.

**LAO:** ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ຈະມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ໂທຫາເບີ **1 844-365-4385 (TTY: 711)**.

**THAI:** เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1 844-365-4385 (TTY: 711)**.

**CHEROKEE:** ᏍᏏᏉᏍᏗ ᏌᏍᏗ ᏍᏗᏂᏃᏍᏗ ᏂᏗᏂᏃᏍᏗ, ᏍᏗᏂᏃᏍᏗ ᏌᏍᏗᏂᏃᏍᏗ ᏂᏗᏂᏃᏍᏗ ᏌᏍᏗᏂᏃᏍᏗ, ᏌᏍᏗᏂᏃᏍᏗ ᏌᏍᏗᏂᏃᏍᏗ ᏌᏍᏗᏂᏃᏍᏗ. ᏌᏍᏗᏂᏃᏍᏗ **1 844-365-4385 (TTY: 711)**.

**Farsi:** توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با شماره **1 844-365-4385 (TTY: 711)** تماس بگیرید.

**Urdu:** خریدار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں **1 844-365-4385 (TTY: 711)**

**BURMESE:** မြန်မာ - သတိ - သင်မြန်မာစကားပြောဆိုပါက သင့်ထံ ဘာသာစကား ကူညီပံ့ပိုးရေး ဝန်ဆောင်မှုများကို အခမဲ့ ပေးဆောင်သွားပါမည်။ သင့်အိုင်ဒီကတ်၏ကျောဘက်ရှိ နံပါတ် သို့မဟုတ် **1 844-365-4385 (TTY: 711)** သို့ ခေါ်ဆိုပါ။

**1. Who is the Medicaid Member?**

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

Readability Statistics	
Counts	
Words	27
Characters	125
Paragraphs	9
Sentences	1
Averages	
Sentences per Paragraph	1.0
Words per Sentence	6.0
Characters per Word	4.0
Readability	
Flesch Reading Ease	59.7
Flesch-Kincaid Grade Level	6.4
Passive Sentences	0.0%
<input type="button" value="OK"/>	