innovation HEALTH

Revocation of Authorization Previously Given to Innovation Health

1. Member Information (Information about person who is revoking authorization)

Last Name		First Name		Middle Initial
Member I.D. Number	Social Security Number	Birthdate *(MM/DD/YYYY)*	Daytime Telephone Number *(include area code)*	
Street Address		City, State and ZIP Code		

2. Authorization To Be Revoked *(Check The Appropriate Box.)*

- ☐ Authorization for Innovation Health to Disclose Health Information to Other Persons or Organizations
- ☐ Authorization for Innovation Health to Request Health Information from Other Persons or Organizations
- ☐ Authorization for Other Persons or Organizations to Disclose Health Information to Innovation Health

Note: If we have more than one authorization on file for a category, ALL will be revoked unless you provide a copy of the specific authorization you are revoking.

3. Important: *Your signature below means that you understand and agree to the following:*

- You revoke your authorization(s) as indicated above for Innovation Health to either use and/or disclose your protected health information, or to request it from others.
- You understand that revocation of your authorization will not have any effect on actions that Innovation Health took before we received your notification.
- You may receive a copy of this form if you request it in writing from the address listed below.

Signature of Member or Legal Representative	Date
Print Name of Member's Legal Representative *(if applicable)*	

If this request is being made or signed by the Member's Legal Representative, you must furnish a copy of the power of attorney or other relevant document designating you as the representative.

Return this completed form to: HIPAA Member Rights Department
PO Box 14079
Lexington, KY 40512-4079
Fax: (860) 907-3017

Innovation Health complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Innovation Health provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512,
1-800-648-7817, TTY: 711,
Fax: 859-425-3379, CRCoordinator@aetna.com.

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

Innovation Health® is the brand name used for products and services provided by Innovation Health Insurance Company or Innovation Health Plan, Inc. Innovation Health is an affiliate of Aetna Life Insurance Company and its affiliates (Aetna). Aetna provides certain management services to Innovation Health. Aetna is part of the CVS Health® family of companies.

TTY: 711

For language assistance in English call the number listed on your ID card at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación. (Spanish)

欲取得繁體中文語言協助，請撥打您 ID 卡上所列的號碼，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an. (German)

ለቋንቋ እገዛ አማርኛ በመታወቅያዎ ላይ በተጠቀሰው ቁጥር በነጻ ይደውሉ (Amharic)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني المذكور في بطاقتك التعريفية. (Arabic)

বাংলায় ভাষা সহায়তার জন্য আপনার আইডি কার্ডে যে নম্বরটি তালিকাভুক্ত রয়েছে বিনামূল্যে তাতে কল করুন। (Bengali)

(Hindi) **हिन्दी में भाषा सहायता के लिए, अपने आईडी कार्ड पर दिये गये नम्बर पर मुफ्त कॉल करें।**

Maka enyemaka asụsụ na Igbo kpọọnọmba edepụtara na kaadị ID gị na akwụghị ụgwọ ọ bụla. (Ibo)

한국어로 언어 지원을 받고 싶으시면 보험 ID 카드에 수록된 무료 통화번호로 전화해 주십시오. (Korean)

Bɛ̀ m̀ ké gbo-kpá-kpá dyé ɖé̱ Bǎsɔ́ɔ̀ wùɖù̱ǔn wɛ̃̀ɛ, ɖá̱ nɔ̀bà bɛ́ ɔ céèà bó nì dyí-dyoìn-bɛ̃̀ɔ̃̀ kɔ̃̀ɛ bó pídyi. (Kru-Bassa)

برای راهنمایی به زبان فارسی، بدون هیچ هزینه ای با شماره ای که بر روی کارت شناسایی شما آمده است تماس بگیرید. انگلیسی (Persian)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру, указанному в вашей ID-карте удостоверения личности. (Russian)

اُردو میں لسانی معاونت کے لیے اپنے ID کارڈ پر درج نمبر پر مفت کال کریں۔ (Urdu)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số được ghi trên thẻ ID của quý vị. (Vietnamese)

Fún ìrànlọwọ́ nípa èdè (Yorùbá) pe nọ́mbà tí a kọ sórí káàdì ìdánimọ̀ rẹ lái san owó kankan rárá. (Yoruba)