Authorization for Release of Protected Health Information

I hereby authorize Aetna Life Insurance Company and any of its parents, subsidiaries, and affiliates (including, but not limited to Aetna Health Management, Inc., Aetna's affiliated HMOs and Aetna Integrated Informatics, Inc.) and their respective employees, agents and subcontractors, to disclose PHI concerning the Member identified below.

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY.

Please Print All Responses

Please submit a separate Authorization for Release of Protected Health Information for each Member for whom Aetna is being requested to disclose protected health information to a third party. If both sides of this form are not completed, as applicable, Aetna will be unable to process your request. Incomplete authorization requests will be returned.

1. Member Information

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

2. Subscriber Information

(The Subscriber is usually the Employee who obtains coverage for his or her family. Please complete this Section if the Subscriber is not the member whose records are being requested.) This Section does not apply to Long Term Care.

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

3. I authorize the individual(s) or company(ies) identified below to receive PHI pertaining to the Member identified in Section 1 above.

Individual or company authorized to receive PHI		Daytime Telephone Number *(include area code)*
Street Address	City, State and Zip Code	
Individual or company authorized to receive PHI		Daytime Telephone Number *(include area code)*
Street Address	City, State and Zip Code	
Individual or company authorized to receive PHI		Daytime Telephone Number *(include area code)*
Street Address	City, State and Zip Code	

4. Purpose(s) for this Authorization

This authorization will apply to any and all requests for PHI, as well as information pertaining to disability and life insurance products, made by the individual(s) or company(ies) named in Section 3 above. It is not necessary to complete Section 4, unless you want to give a partial authorization.

If you prefer to authorize disclosure of only selected categories of information, please indicate below which types of information may be disclosed.

☐ Health (This includes medical, dental, pharmacy, vision, and flexible spending account information)

☐ Behavioral Health (e.g., mental health, drug and alcohol abuse treatment)

☐ Disability ☐ Life Insurance ☐ Long Term Care

This authorization will be in effect for one year from the date signed, unless you indicate a shorter period below.

_____ through _____

mm/dd/yyyy mm/dd/yyyy

4. Purpose(s) for this Authorization (continued)

This authorization will apply to all PHI maintained by Aetna, unless you specify certain categories below.

Description of the information to be released or disclosed: (*check all that are appropriate*)

- ☐ Application or enrollment information
- ☐ Claim status
- ☐ Claim records
- ☐ Patient management records
- ☐ Other: *(please specify)* _____

5. IMPORTANT: Your signature below means that you understand and agree to the following:

- The PHI disclosed pursuant to this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, sexually-transmitted diseases, HIV/AIDS, and/or genetic marker information.
  These records will be included in the information we will make available to the individual(s) or company(ies) identified in Section 3 above.
- Information disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy regulations.
- If we receive requests for copies of claims and encounter information from the individual or company you have named in Section 3, we may charge a reasonable fee (except where prohibited by law) to defray our copying and mailing costs.
- Your ability to enroll in an Aetna plan, and your eligibility for benefits and payment for services, will not be affected if you do not sign this form. (However, without your signature, your request to release information to the individual(s) named in Section 3 above will not be honored.)
- You may receive a copy of this signed form if you ask for it by writing to the address listed at the bottom of this page.
- This authorization will expire one year from the date you sign this authorization. If you sign this form, you may revoke the authorization at any time by notifying Aetna in writing at the address below. Revoking this authorization will not have any effect on actions that Aetna took in reliance on the authorization before we received the notification.

6. Signature of Member or Member's Legal Representative.

Minors* must sign this form below ***if*** (check applicable box):		All others must sign this form below as(check applicable box):	
1. ☐ the minor is married or emancipated or, 2. ☐ the information being authorized for release pertains to drug or alcohol treatment or, 3. ☐ the information being authorized for release pertains to mental health treatment and applicable state law allows minors to receive such treatment without parental consent. * < age 19 (NE and AL); < age 21 (PA); < age 18 (all other states)		4. ☐ the member or member's legal representative or, 5. ☐ the parent of unemancipated minor, unless minor has signed at left *and* box 3 at left has been checked or, 6. ☐ the parent of unemancipated minor if the information authorized for release pertains to drug or alcohol treatment and applicable state law does NOT allow minors to receive such treatment without parental consent (Note: in this case, signature of both parent and minor are required.)	
Signature	Date	Signature	Date
Print Name		Print Name	

If the person signing this Authorization is not the Member, describe relationship to the Member (i.e. Parent, Legal Representative):

If this authorization is being signed by the Member's Legal Representative, you must furnish a copy of the health care power of attorney, or other relevant document authorizing you to act on the Member's behalf.

Return this completed form and relevant documentation, if required, to:

Aetna Legal Support Services
151 Farmington Avenue, W121
Hartford, CT 06156-9998
Fax: (860) 907-3017

NOTICE TO RECIPIENT(S) OF INFORMATION (Section 3. above):
Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.