



Authorization For Aetna To Request Protected Health Information

1. MEMBER INFORMATION (Information About Person For Whom This Authorization Is Requested.)

Last Name	First Name	Middle Initial
Claim Number	Year of Birth	Daytime Telephone Number (include area code)
Street Address	City, State and ZIP Code	

PLEASE READ THE FOLLOWING CAREFULLY BEFORE COMPLETING YOUR AUTHORIZATION. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

This form requests a Member's unconditioned authorization for Aetna to ask another person or organization to disclose Member's Protected Health Information ("PHI") to Aetna for the following purpose(s).

The specific PHI we are asking you to authorize Aetna to request is (This section completed by Aetna.)

2. By signing this form, you will authorize Aetna to request PHI described above from the following persons or organizations (or classes of persons or organizations).

3. Expiration of this Authorization (Select one.)

<input type="checkbox"/> On the following date: ____/____/____ <input type="checkbox"/> When the following event occurs.

Please review and complete important information on the reverse of this form.

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

- You authorize Aetna to request from the persons or organizations named above the PHI described above for the purposes stated above.
- The information to be disclosed may be protected by law. Information disclosed under this authorization may be redisclosed and no longer protected by federal privacy regulations.
- Your ability to enroll in an Aetna plan, your eligibility for benefits and payment for services will not be affected if you do not sign this form.
- You may revoke the Authorization at any time by notifying Aetna in writing, but if you do that, it won't have any effect on actions that Aetna takes before we received your notice.
- You may receive a copy of this form if you request it in writing from the address listed below.
- You agree that, unless you provide a written restriction in Section 1 above, you have expressly authorized the release to Aetna of information concerning treatment of mental illness, alcohol or substance abuse, Human Immunodeficiency Virus (HIV) infection, or Acquired Immune Deficiency Syndrome (AIDS).

5. Signature of Member/Insured or Legal Representative.

Signature of Member/Insured or Legal Representative	Date
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Print Name

If not the Member, describe your relationship to the Member:

Natural or Adoptive Parent of Unemancipated Minor Child

Other Legal Representative

If this authorization is being signed by Member/Insured's legal representative (other than a parent of an unemancipated minor child), you must furnish a copy of the health care power of attorney, or other relevant document designating you as the representative.

NOTICE TO RECIPIENT(S) OF INFORMATION (Section 2. above):

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individuals' family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. **Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.**

To be filled in by Aetna:

Return this completed form to:

_____ Aetna Business Area Name

_____ Aetna Street Address

_____ City, State, ZIP Code

_____ Attn: Contact Name and Mail Location

Contact Telephone Number: _____

Contact Fax Number: _____